Fifth Annual Report

of the

Domestic Violence Death Review Committee

Office of the Chief Coroner
Province of Ontario
2007

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Appendices

Message from the Chair

The Domestic Violence Death Review Committee (DVDRC) of the Office of the Chief Coroner experienced another busy year of case reviews in 2007, with the total number reaching a modest, all-time high of fifteen cases comprising twenty-four deaths. Regrettably, there continue to be roughly thirty incidents in Ontario annually where at least one domestic homicide results. Many of these cases may be deferred for years prior to review by the Committee, as the matter may be before the courts for criminal prosecution.

Readers of this report are reminded that, in keeping with the defined mandate of the DVDRC (see Appendix A), the reviews are restricted to situations where a homicide has taken place that involves a person and/or his/her child(ren) committed by the person's intimate partner or ex-partner. The homicide(s) may be followed by the suicide of the perpetrator. Due to resource and time limitations, the Committee does not review attempted homicides or cases where the only manner of death was suicide (i.e. no homicide took place).

As the number of reviewed cases and our cumulative database expands, the DVDRC notes that many issues and themes seem to recur from case to case, and consequently, we feel an obligation to repeat recommendations that have been made with previous cases and previous annual reports. As with last year's report, the Committee has attempted to direct recommendations to the agencies, organizations and ministries deemed mostly likely suitable to respond.

While the Office of the Chief Coroner anticipates that the same careful consideration should be given to Committee recommendations as is given to inquest jury recommendations, we have no mechanisms to measure implementation or success. On the fifth anniversary of the DVDRC's operations, we feel it would be worthwhile for a government inter-ministerial committee to conduct an audit of responses to recommendations, in an attempt to better understand the magnitude of the impact the work of the Committee is having. This recommendation is highlighted in Chapter One of this report.

The findings and recommendations of the Committee are dependent on the quality of the investigation into the incident, and documentation provided by police services, Children's Aid Societies, medical and mental health professionals, and all support agencies that might have been involved in providing services. It is critically important that in-depth reviews be carried out by local agencies, whether there are likely to be criminal prosecutions or not. The support to the Committee and cooperation provided by all agencies involved in domestic violence prevention is acknowledged and greatly appreciated.

William J. Lucas, MD CCFP
Regional Supervising Coroner
Chair, Domestic Violence Death Review Committee

Committee Membership

William Lucas, MD, CCFP.
Committee Chair
Regional Supervising Coroner
Chair of the Domestic Violence Death Review Committee

Karen Bridgman-Acker, MSW, RSW
Child Welfare Specialist
Paediatric Death Review Committee

Myrna Dawson, Ph.D.
Associate Professor,
Department of Sociology & Anthropology
University of Guelph

Len Favreau, M.A.
Inspector, Officer-in-Charge Court Services
Peel Regional Police

Vivien Green
Executive Director, Woman Abuse Council of Toronto.
Member of Ontario Government commissioned Joint Committee on Domestic Violence

Peter Jaffe, Ph.D., C.Psych
Professor, Faculty of Education, Academic Director, Centre for Research on Violence Against Women & Children
University of Western Ontario

Beth Jordan
Managing Director, Adobe Consulting Services.
Former Director of Programs & Services, Assaulted Women's Helpline and Co-Founder of the provincial Cross-Sectoral Violence Against Women Strategy Group.

Robert Morris
Crown Attorney, Ministry of the Attorney General.
Co-founded the first Domestic Assault Review Team (DART) in Canada.
Implemented the first questionnaire for domestic assault victims to identify risk and potential lethality.

Deborah Sinclair, M.S.W.
Social Worker
Founding member of the Emily Stowe Shelter for Women.
Author of 'Understanding Wife Assault', 'In the Centre of the Storm, Durham Speaks Out', 'Overcoming the Backlash' and other articles and papers related to violence against women and children.

Kevin Sisk
Assistant Crown Attorney, Ministry of the Attorney General since 1991
Former Co-lead Simcoe County Domestic Violence Court Project.
Member Domestic Assault Review Team (DART), Midland

Lynn Stewart, Ph.D., C.Psych.
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Marcie Campbell, M.Ed
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Research Assistant, Centre for Research on Violence Against Women and Children

Staff Sergeant Dominic Beckett, O.P.P.
Executive Officer

Julie McCreary
Administrative Assistant

Chapter One
Introduction and Overview

Mandate

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory Committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene May / Randy Iles and Gillian and Ralph Hadley. The mandate of the DVDRC is to assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice, healthcare sector, social services and other public safety agencies and organizations. By conducting a thorough and detailed examination and analysis of facts within individual cases, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.

Since its inception, the DVDRC has reviewed 62 cases that involved a total of 100 deaths. The following chart details the number of cases and deaths reviewed since the establishment of the DVDRC in 2003:

Year	# of cases reviewed	# of deaths involved
2003	11	24
2004	9	11
2005	14	19
2006	13	21
2007	15	25
Total	**62**	**100**

The results of the data collection process are detailed in the statistical analysis presented in Chapter 2 of this report. Risk factor definitions are included in **Appendix "B"**

The summaries and recommendations resulting from each of the 15 cases reviewed in 2007 are presented in Chapter 3 of this report.

Recommendations

The DVDRC commenced its reviews in 2003 and is finding that due to recurring issues and themes, recommendations made by the Committee are now repeating themselves. It is the hope of the Committee that all agencies give the same careful contemplation to the implementation of recommendations as was given to their creation. As such, the DVDRC is recommending that an audit be conducted of all recommendations made by this Committee since its inception. Our recommendation is as follows:

It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government responses to recommendations that have been made by the DVDRC since its inception. It is suggested that this committee develop a work plan and timeline on the implementation of recommendations and consult with the Domestic Violence Advisory Council that currently reports to Minister for Women's Issues. It is hoped that the final report and plan could be forwarded to the Attorney General and made available to the public.

Review and Report Limitations

All information obtained as a result of coroners' investigations and provided to the DVDRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* of Ontario and the *Freedom of Information and Protection of Privacy Act*. Unless and until an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Accordingly, individual reports as well as the review meetings and any other documents or reports produced by the DVDRC remain private and protected and will not be released publicly. Each member of the Committee has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

The terms of reference for the DVDRC direct that the Committee, through the Chairperson, reports annually to the Chief Coroner regarding the trends, risk factors, and patterns identified through the reviews, and makes appropriate recommendations to prevent deaths in similar circumstances.

The case summaries included in Chapter 3 are intended to provide a general sense of the circumstances that led to the deaths and subsequent issues that were considered by the committee when formulating recommendations. The summaries are an overview of key elements of the case and do not necessarily include all details or issues examined by the DVDRC.

Disclaimer

The following disclaimer applies to individual case reviews and to this report as a whole:

> This document was produced by the DVDRC for the sole purpose of a coroner's investigation pursuant to section 15 (4) of the *Coroners Act*, R.S.O. 1990 Chapter c. 37, as amended. The opinions expressed do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusion of the investigation may differ significantly from the opinions expressed herein.

Chapter Two
Statistical Overview

In 2007, the DVDRC reviewed 15 cases involving domestic violence.[1] Review by the Committee does not take place until the coroner's investigation and all applicable criminal proceedings and appeals have been concluded. Because of these constraints, and because the review process is time-consuming only a limited number of cases can be reviewed per year.

Table 1 below outlines the total number of domestic homicides that occurred in Ontario between 2002 and 2006. There were a total of 143 domestic homicide cases resulting in 196 fatalities involving 121 women, 20 children, and 55 men. The majority of male deaths were suicides by the perpetrator (46 of 55 deaths). Please note that comparison with other data sources should be done cautiously as different organizations may have differing criteria for defining domestic homicides. For example, Statistics Canada publishes data on homicides based on police reports that are not modified after subsequent court proceedings or revised coroners' findings.

Table 1 –Domestic Homicides in Ontario 2002-2006[2]

Year	Incidents	Deaths	Women	Children	Men
2006	30	44	26	12	6 (4 perpetrators)
2005	31	38	27	0	11 (11 perpetrators)
2004	29	39	24	1	14 (12 perpetrators)
2003	25	32	22	1	9 (8 perpetrators)
2002	28	43	22	6	15 (11 perpetrators)
Total:	**143**	**196**	**121**	**20**	**55 (46 perpetrators)**

There was an apparent appreciable increase in the number of children's deaths in 2006, the significance of which is not known. The Committee will continue to monitor this issue in future reports.

The DVDRC has analyzed basic information gleaned from the 143 cases from 2002 to 2006. The information gathered from this sample is presented in the following tables to assist the reader.

Table 2 illustrates that the majority of domestic violence fatalities involved a single homicide, followed by homicide-suicide, attempted homicide-suicide, attempted homicide and related homicide, i.e. police shooting.

Table 2 – Types of Domestic Violence Fatalities

Type	Number of Cases	Percent % (n=143)
Homicide	96	67.0 %
Homicide-suicide	33	23.0 %
Attempted homicide-suicide	11	8.0 %
Attempted homicide and related homicide	3	2.0 %
Total	**143**	**100 %**

[1] One case was subject to a full inquest
[2] Numbers are based on statistics from the Office of the Chief Coroner

Table 3 shows that the majority of perpetrators of domestic homicides are male and the majority of victims are female. These statistics are consistent with past reports and past research.[3] The main cause of death in Ontario for victims has been stabbing, followed by shooting. Approximately 31% of the 143 domestic homicide cases in Ontario involved the perpetrator committing suicide after killing or attempting to kill their partner or ex-partner. Almost half of the perpetrators killed themselves by a self-inflicted gunshot wound.

The majority of domestic homicides occur in a residence, with most occurring in the couple's shared residence or in the residence of the victim (if separated).[4]

Table 4 illustrates that domestic homicides are not isolated to highly populated urban centres. Smaller communities (population of 50,000 or less) represent only 5% of Ontario's population but over 25% of all domestic homicides.

Table 3 – Descriptive Factors of all Domestic Violence Fatalities

Category	Variable	Number of Cases	Percentage %
Gender of Victim	Female	134	94%
	Male	9	6%
Gender of Perpetrator	Female	9	6%
	Male	134	94%
Cause of Death for Victims	Stabbing	49	34%
	Shooting	29	20%
	Other	65	45%
Cause of Death for Perpetrators	Shooting	22	47%
	Other	25	53%
Location of Domestic Homicides	Residence	114	80%
	Other	29	20%

Table 4 – Number of Domestic Homicides in Specific Populated Cities

Population	Number of Cases	Total Population	Percentage of Ontario's Population % (12,160,282)	Percentage of all Domestic Homicides in Ontario %
Over 1,000,000	32	2,503,281	21.0 %	22.4 %
500,001 to 1,000,000	23	3,203,144	26.0 %	16.1 %
100,001 to 500,000	37	3,661,100	30.0 %	25.9 %
50, 001 to 100,000	13	596,810	5.0 %	9.1 %
10,001 to 50,000	23	461,903	4.0 %	16.1 %
0 to 10,000	15	58,784	0.5 %	10.5 %

[3] Campbell, J.C., Glass, N., Sharps, P.W., Laughon, K., & Bloom, T. (2007). Intimate partner homicide: Review and implications of research and policy. *Trauma, Violence, & Abuse,* 8(3), 246-269.

[4] Source-Coroner's reports for place of injury/death

Statistical Overview of Cases Reviewed by the Committee

The remainder of this chapter and summary tables that follow presents data from the 15 cases that the DVDRC reviewed in 2007 as well as an overview of all cases reviewed since 2003. This year the DVDRC reviewed five cases that occurred in 2003, four cases from 2004, five cases from 2005, and one case from 2006.

Table 5 compares characteristics of victims and perpetrators to provide insight into some of the possible risk factors for domestic homicides. Similar to past reports, the majority of perpetrators were male, with over half of them having a criminal history (not necessarily related to domestic violence). A high percentage of victims and perpetrators had significant life changes prior to the domestic homicide, including a separation or pending divorce, or a major medical problem or financial difficulties.

Table 5 – Characteristics of the Victims and the Perpetrators

Category	Variable	2007				2003-2007 Combined			
		Victim (n = 15)		Perpetrator (n = 15)		Victim (n = 62)		Perpetrator (n = 62)	
Gender	Female	14	93%	2	13%	58	94%	5	8%
	Male	1	7%	13	87%	4	6%	57	92%
Age (years)	Min	18	-	21	-	15	-	17	-
	Max	72	-	61	-	81	-	89	-
	Mean	38	-	39	-	39	-	42	-
Citizenship	Canadian	12	80%	9	60%	51	82%	49	79%
	Other	3	20%	6	40%	11	18%	13	21%
Employment	Employed	8	53%	5	33%	29	47%	23	37%
	Unemployed	5	33%	7	47%	16	26%	23	37%
	Other	2	13%	3	20%	17	27%	16	26%
Criminal History	Yes	5	33%	10	67%	10	16%	36	58%
Prior Counselling	Yes	3	33%	6	40%	21	34%	26	42%
Significant Life Changes	Yes	12	80%	13	87%	40	65%	55	89%

Table 6 shows the majority of domestic homicides occurred within couples who were legally married for a period of ten years or less. Many of these couples had children in common. From 2003 to 2007, the DVDRC reviewed a total of nine domestic homicide cases that involved children's deaths. Within these, a history of violence or threats towards the children by the perpetrator was present in only four of the reviewed cases and in seven the perpetrator was seen as depressed by family, friends, etc.

Table 6 – Relationship between Victim and Perpetrator

Category	Variable	2007		2003-2007 Combined	
		n = 15		n = 62	
Type of Relationship	Legal Spouse	6	40%	35	56%
	Common-law	5	33%	11	18%
	Boyfriend/girlfriend (incl. same sex)	4	27%	16	26%
Length of Relationship	<1 year	2	13%	5	8%
	1 – 10 years	9	60%	33	53%
	11 – 20 years	3	20%	12	19%
	Over 20 years	1	7%	12	19%
Children In Common	0	8	53%	26	42%
	1-2	6	40%	26	42%
	3+	1	7%	10	16%

Although the majority of domestic violence fatalities reviewed by the DVDRC in 2007 were homicides (Table 7), 13% of the cases reviewed were classified as multiple homicide-suicides with the multiple victims most often including children and/or the victim's new partner. The main causes of death for victims remain stabbings and gunshot wounds.

Table 7 – Domestic Homicide Information

Category	Variable	2007		2003-2007 Combined	
		n = 15		n = 62	
Type of Case	Homicide	8	53%	24	39%
	Homicide-suicide	5	33%	23	37%
	Attempt homicide-suicide	0	0%	9	15%
	Multiple homicide-suicide	2	13%	4	6%
	Multiple homicide	0	0%	2	3%
Cause of Death for Victims	Stabbing	4	27%	21	34%
	Shooting	3	20%	17	27%
	Other	8	53%	24	39%

Table 8 analyzes the common risk factors present in cases reviewed that have been shown to increase the risk of lethality. Consistent with past DVDRC reports, the most common risk factor involved with a domestic homicide case is an actual or pending separation. Research has shown that an actual separation coupled with a highly controlling abuser significantly increases the risk of a domestic violence fatality.[5][6] A history of domestic violence, followed by non-diagnosed reports of depression, obsessive behaviour, and escalation of violence are other volatile risk factors. For definitions of the above terms, refer to the Ontario Domestic Violence Death Review Committee Risk Factor Coding Form in **Appendix "B"**

Other factors that may exacerbate problems in intimate relationships include the victim and/or the perpetrator experiencing poor health, financial difficulties, isolation, mental health issues, gambling addiction, conflict with extended family members, and age disparity with their (ex) partner.[7]

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[5] Campbell, J.C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M.A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S.A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health,* 93(7), 1089-1097.

[6] Campbell, J.C. (1992). *If I can't have you, no one can: Power and control in homicide of female partners.* In D.E. Russell (Ed.), Femicide: The Politics of Women Killing. New York: Twayne.

[7] Shackelford, T. K, & Mouzos, J. (2005). Partner killing by men in cohabiting and marital relationships: A comparative, cross-national analysis of data from Australia and the United States. *Journal of Interpersonal Violence*, 20 (10), 1310-1324.

Research has found that women in marital or cohabitating relationships are at a higher risk of experiencing domestic homicide if their partner is significantly older or younger. Eighteen percent of the 60 cases the Committee reviewed had couples with an age disparity of 10 or more years. The average age difference within these cases is 15 years.

Table 8 – Common Risk Factors from DVDRC Review

Risk Factors	2007		2003-2007	
	n (n=15)	Percentage	n (n=62)	Percentage
Actual or pending separation	11	73%	49	79%
History of domestic violence	11	73%	47	75%
Perpetrator depressed in the opinions of non-professionals (e.g., family, friends, etc)	7	47%	39	63%
Obsessive behaviour displayed by perpetrator	11	73%	39	63%
Escalation of violence	8	53%	36	50%
Prior threats to kill victim	8	53%	31	45%
Prior threats to commit suicide	6	40%	28	44%
Prior attempts to isolate victim	6	40%	27	44%
Access to or possession of firearms	7	47%	27	42%
Control of most or all of victim's daily activities	9	60%	26	40%
Excessive alcohol and/or drug use	4	27%	25	40%
Perpetrator unemployed	5	33%	25	39%
History of violence outside the family	7	47%	24	34%
Prior threats with a weapon against victim	7	47%	21	34%
New partner in victim's life	7	47%	21	32%
Perpetrator failed to comply with authority	5	40%	20	31%
Perpetrator was abused and/or witnessed domestic violence as a child	4	27%	19	31%
Perpetrator displayed sexual jealousy	5	33%	19	31%
Extreme minimization and/or denial of spousal assault history by perpetrator	6	40%	19	31%
History of violence or threats against children	3	20%	17	27%
Prior hostage-taking or forcible confinement	5	33%	14	23%
Other mental health/psychiatric problems	3	20%	12	19%
Victim and perpetrator living common-law	5	33%	11	18%
Child custody or access disputes	1	7%	9	15%
Presence of stepchildren in the home	5	33%	9	15%

It is of considerable concern to the DVDRC that a number of cases appeared predictable and preventable in hindsight based on the high number of risk factors that were present. The DVDRC considers a case predictable and potentially preventable if there are seven or more known risk factors present.

Figure 1 and Figure 2 illustrate the number of risk factors present in the cases the Committee has reviewed. The recognition of multiple risk factors within a relationship experiencing domestic violence allows for enhanced risk assessment and safety planning that may prevent a possible homicide.

Figure 1 – Number of Risk Factors Identified in Cases Reviewed in 2007

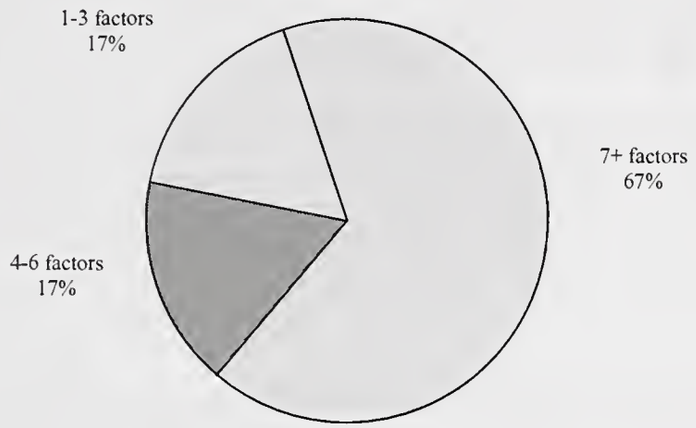
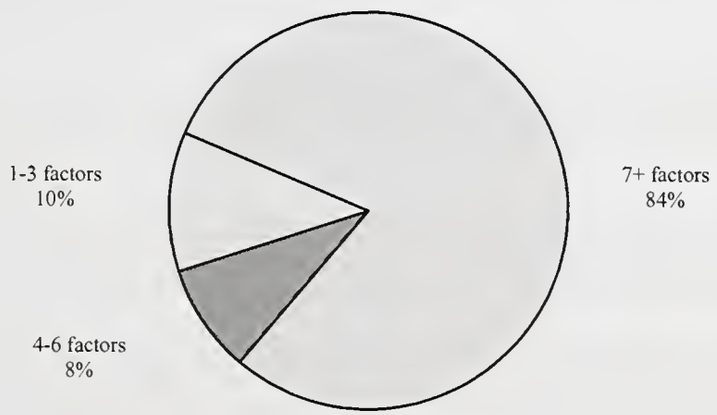


Figure 2 – Number of Risk Factors Identified in Cases Reviewed for 2003-2007



Chapter Three
Case Summaries and Recommendations

OCC File No. 2003-15895

This case involved the homicide of a female victim by her ex-spouse who had a long history of alcohol abuse and mental health issues. The victim and the perpetrator had been divorced for two years following an eleven-year marriage. They had one child. The relationship had been plagued with violence and threats by the perpetrator against his spouse, including sexual assaults, threats with a weapon, some of which lead to criminal convictions. Despite numerous appearances before the courts, there were many instances of breach of bail and/or probation conditions.

The perpetrator became increasingly obsessed with reconciliation with his ex-spouse after their separation, with escalating aggression, threats of violence and death, and stalking behaviour. On the day of the homicide, the perpetrator went to the victim's house and broke in after the victim denied him entry. When she again refused his pleas for reconciliation, and while their son was present in the home, the perpetrator stabbed her multiple times.

No systemic issues or points of intervention were identified in this case, hence no recommendations.

Comment: The perpetrator was repeatedly non-compliant with non-communication orders, and to a certain extent this was tolerated by the victim. No apparent systemic gaps were identified for recommendations in this case.

OCC File No. 2004-15678/2004-15672/2004-15670

This case involved the homicide of a male victim and a female child, and the subsequent suicide by the female perpetrator. The victim and perpetrator had been in a common-law relationship for about 4 years, and had three children. The perpetrator was a full-time homemaker, and showed signs of being overwhelmed by the burden of caring for three young children. She most likely was suffering from a significant post-partum depression.

The victim worked out of a home office, and exhibited behaviours described by some observers as demanding, demeaning and controlling of his spouse. There was, however, no formal history of domestic violence incidents with police, and family members were not aware of any significant relationship difficulties.

The perpetrator left a suicide note blaming herself for being a poor mother. She then proceeded to stab her husband multiple times, and inflicted cutting wounds to two of her children, before stabbing herself. One child died enroute to hospital, and the other survived her injuries.

Recommendation 1

To the Ontario Women's Directorate (OWD):

It is recommended that all Government agencies involved with victims and perpetrators continue to educate the public about domestic violence including information on the dynamics and/or warning signs of domestic violence and an awareness of the risk factors for potential lethality. (Similar to recommendation #1/2002)

In addition, such programs should include information on where and how to ask for help, and when to take appropriate action with potential abusers, victims, and their children. These programs should also underscore the fact that Intimate Partner Violence (IPV) and postpartum depression can have a similar negative impact on a woman's functioning and well-being.

Recommendation 2

To the College of Family Physicians of Canada, Canadian Pediatric Society, Society of Obstetricians and Gynecologists, College of Midwifery of Ontario:

It is recommended that organizations involved in educating health professionals, such as the College of Family Physicians of Canada, Canadian Pediatric Society, the Society of Obstetricians and Gynecologists, and the College of Midwifery of Ontario, promote educational programs that explore the dynamics and/or warning signs of domestic violence and the potential for lethality, especially when working with patients who have depression and/or anxiety. In addition, such programs need to highlight for practitioners caring for women and/or their children that IPV can lead to and/or exacerbate an underlying depression. (Similar to recommendation #12/2004 & #12/2006 & #15/2006)

Comment: Although similar to previous recommendations focusing on the need for education for physicians, this more broadly emphasizes the need for those assessing and treating the children to be cognizant of the impact IPV may have on them, and to consider making enquiries of the parents who may be involved in turbulent domestic situations.

OCC File No. 2006-6306; 2006-6305; 2006-6304

This case involved the homicide of two teenaged girls, by their father, and his suicide. The perpetrator and his wife had been in a relationship for 16 years, during which they had separated on three occasions. He had a long history of medical disability, including chronic back pain, anxiety and depression, which prevented him from maintaining meaningful employment. His ongoing medical management for these difficulties appeared to be primarily through his family doctor, although he had several admissions to psychiatric facilities due to suicidal ideation.

The perpetrator had an aggressive and controlling personality, and exhibited abusive language and physical abuse to his spouse. The children often witnessed harassment, threatening behaviour, and even death threat utterances against their mother. Despite numerous incidents involving police and the courts, there were no formal court ordered visitation/access arrangements in place, with the children opting to visit their father on a regular basis.

During one such visit, the father accompanied by his two children, purposefully drove his vehicle into the path of an oncoming truck, killing all three. The perpetrator had left several suicide notes indicating his intent on taking his own life as well as his children's.

Recommendation 3

To the Ontario Association of Chiefs of Police (OACP) and Ontario Police College (OPC); Ministry of Community Safety and Correctional Services (MCSCS), Policing Standards Division:

It is recommended that there be ongoing training for police on the most effective response to domestic violence cases especially where there is a history of homicidal and suicide threats, separations, obsession with the victims, prior incidents of domestic violence and/or child abuse. (Similar to recommendation #4/2002 & #16/2004)

The development of a high-risk case management protocol specific to these complicated domestic violence cases needs to be accompanied by additional training focused on addressing the dual goals of victim safety and offender risk reduction.

Comment: Police were called on several occasions. The risk factors were high and prevalent in this case, suggesting that some form of intervention was potentially possible.

Recommendation 4

To the Ontario Women's Directorate (OWD):

It is recommended that OWD continue to educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and suicide prevention. Also, OWD should provide information to help the public and professionals understand their role in assisting abusers, victims and their children. (Similar to recommendation #1/2006)

Comment: Friends, family and employers witnessed verbal insults, stalking and aggressive behaviour. On several occasions the perpetrator verbalized suicidal and homicidal threats. Friends, family and employers did their best to support both him and his wife but did not seemingly comprehend the high-risk nature of this case. His spouse also would have benefited from more information on her rights as it seemed she was unaware that she could report threats and verbal abuse even if she did not hear them directly.

Recommendation 5

To the College of Family Physicians of Canada:

It is recommended that healthcare providers be taught to be mindful of the dynamics of domestic violence and the potential for lethality, especially when working with patients who have a history of drug abuse, depression, anxiety, and suicidal ideation, particularly when there is high conflict in their marriage and a history of numerous separations. (Similar to recommendations #12/2004 & #12/2006)

Comment: In this case, the family doctor provided a long-term supportive role to the abuser but did not document any screening for issues related to domestic violence and escalating high risk indicators of lethality, i.e. prior domestic violence, separation, depression, suicidal and homicidal threats and concerns about children. Other health care providers had contact with this patient as well and seemed unaware of the high-risk nature of the case.

OCC File No. 2004-2221

This case involved the homicide of a female victim by her male partner. Both were First Nations people living in a remote northern community. The victim and perpetrator had been in a turbulent relationship for about two years. The victim had a significant problem with alcohol abuse, along with mental health issues. The perpetrator also had significant problems with both alcohol and drugs, and had a lengthy criminal record including sexual assault, uttering death threats, break and enter, and numerous breaches of court orders. He was described as controlling, jealous and aggressive, taking steps to isolate the victim from her family. The couple was also known to have several incidents of domestic events, particularly when they were drinking. When police became involved, including an incident about six weeks prior to the fatal one, no charges were laid.

On the day of the incident, the couple had been drinking heavily. Family members had been in attendance, and were upset by the arguing and fighting they observed between the couple. The victim appeared fearful of the perpetrator, but would not leave with her family when requested to do so. She was later reported deceased by her partner. Her death was attributed to blunt force traumatic injuries to the chest and abdomen.

Recommendation 6

To the Ontario Association of Chiefs of Police (OACP); First Nations Police; First Nations Police Association & Ministry of Community Safety & Correctional Services (MCSCS) Policing Standards Division:

Recognizing the critical role that police play in responding to domestic violence calls, particularly in rural and remote communities where frequently they are the only resource available to families in trouble, police officers require ongoing training in the dynamics of domestic violence especially when faced with reluctant and ambivalent victims and perpetrators who have a history of past domestic violence, suicidal behaviour and addictions. (Similar to recommendations #7/2002, #5/2002, #4/2002, #8/2004 & #28/2006)

Comment: In previous reports we recommended that police and other front-line workers (health/educational/social) need to be made aware of the resources available in their respective communities to address issues of family breakdown, conflict, and mental health concerns, and to make referrals when necessary. We also recommended that cross-cultural and cultural competence training should be a mandatory component of all training programs for front line workers, such as police, healthcare, and social workers. In addition to these recommendations, we also advised that police receive ongoing training in the dynamics of Domestic Violence to assist officers with assessing situations and laying charges where appropriate.

In this case, the police were called a few weeks earlier by the victim's family to intervene in a domestic situation with her partner. No charges were laid and her partner left the home for a week. In general, this appeared to be a missed opportunity to do an intervention with the family in terms of safety planning, risk identification and case management. Given the perpetrator's long criminal history and previous charges related to violence, and known history of addiction, regardless of the victim's ambivalence, this family would have benefited from a proactive policing response.

Recommendation 7

To the Government of Ontario (Ministry of Aboriginal Affairs), Government of Canada (Department of Indian Affairs):

We recommend that First Nation communities be prioritized by government to address the enormous lack of resources available to them, including making available culturally appropriate service providers that would be adequately trained in providing an effective response to the complex issues facing Aboriginal families. These issues include the impact of intergenerational trauma on families with the consequence of high rates of mental health issues, addictions, domestic violence, unemployment and living in chronic states of poverty. (Similar to recommendation #28/2004)

Comment: In our 2004 report, we recommended that additional resources be made available to develop or provide access to domestic violence services for people living in northern (rural and remote) communities. This recommendation builds on the needs identified in the previous report, particularly given the high incidence of domestic violence in Aboriginal communities.

In this case both victim and perpetrator grew up in First Nations communities that lacked many resources. They had little access to a support system outside of their families and friends. Both struggled with addictions yet there was little opportunity for intervention. In the perpetrator's case, he was in an out of group homes from a very young age and yet there was no treatment of any sort documented that would have assisted him in his younger years.

Recommendation 8

To Ontario Works:

We recommend that Ontario Works ensure that all of its employees are well trained in recognizing situations of domestic violence and assisting their clients in obtaining the services they require.

Comment: Both victim and perpetrator received financial assistance from the Ontario Works program. In underserviced communities such as the one in this case, it is especially critical that all service providers including Ontario Works staff be well trained in the dynamics of domestic violence and be familiar with how to educate and help families access the services they require. Excellent training materials have been developed for training but it is unknown how many of the Ontario Works staff have actually had the training.

Recommendation 9

To Healthcare Providers:

It is suggested that healthcare providers take a more proactive stance, particularly when working with patients in crisis situations, to ask those patients if there are any safety concerns in their intimate relationships. If the provider senses there are concerns, we recommend they use a such danger assessment tool[8], which will assist both the healthcare provider and the patient to better understand if there is a risk of lethality.

Comment: In the 2004 report, we had recommended that all healthcare providers be taught to be mindful of the dynamics of domestic violence and the potential for lethality, especially when working with patients who have a history of alcohol and/or drug abuse, depression, anxiety, or suicidal ideation. Suicide attempts are often an attempt on the part of the victim to escape abusive relationships.

The victim, a young First Nations woman with alcohol addiction problems, was brought by her family to an emergency department at a nearby hospital on a suicide attempt. Her suicide attempt was precipitated by a recent separation from her partner, who had just left her the week before, after the police had been called to their home regarding a domestic violence complaint. No charges had been laid. Given the combination of a suicide attempt, domestic violence, addiction, and a recent separation, she would have benefited from an in-depth lethality assessment by the healthcare provider. She and her family would have benefited from education on the warning signs and escalating risk factors that she was faced with and this intervention may have helped her better understand the danger she was in. Her partner killed her within weeks.

Recommendation 10

To the Ontario Women's Directorate (OWD):

Kanawayhitowin is an Aboriginal public awareness campaign that was launched in the fall of 2007 to raise awareness about the signs of woman abuse in First Nations communities, so that people who are close to at-risk women or abusive men can provide support. It reflects a traditional and cultural approach to community healing and wellness. Educational materials include brochures, public service announcements, a training video and CD-ROM. We recommend that the OWD consider making this campaign available to all Aboriginal communities across the province.

Comment: In this case, family, friends and neighbours were very concerned about the victim and perpetrator's relationship. They did everything they could to assist the victim but they did not know how to deal with her minimization of the abuse and her ambivalence about separating from her partner. This community would have benefited greatly from the Kanawayhitowin campaign, which was unfortunately not available to them at that time.

[8] http://www.dangerassessment.org/WebApplication1/pages/product.aspx

OCC File No. 2003-14776

This case involved the homicide of a teenaged female victim by her former male partner. The victim had dropped out of school around the time the relationship began, and soon afterwards became pregnant. The perpetrator had a history of drug and alcohol abuse, and a criminal record. Over the next couple of years, the perpetrator and victim had a stormy relationship, with numerous incidents of physical abuse and assaults, forcible confinement, damage to property and threatening. On one occasion he was charged and convicted of spousal assault, and the probationary terms prohibited his association with the victim. By this time the couple had separated, and she had returned to school through a school-parenting program. The perpetrator continued to contact her repeatedly, threatening suicide and stalking and intimidating her and any of her male associates. Police made application for a warrant for his arrest for a further domestic assault, but this was not put on the CPIC system in a timely fashion, leading to a missed opportunity to apprehend him during a routine traffic stop by another police service just days before the homicide.

One day before the homicide, the victim confided her concerns to tutors at school, but they were unable to provide any information to her regarding helpful domestic assault contact services prior to her death. On the day of the incident, the perpetrator gained entry into the victim's home and shot her.

Recommendation 11

To the Ministry of Education:

It is recommended that the Ministry of Education who provides funding for Adult Education, alternative education programs, and regular school programs that may involve young parents, ensure that education and training is provided to individuals who deal with young parents in such programs on how to respond to suspected or known cases of intimate partner violence among their clients.

Comment: This case is an excellent example of how various agencies have the potential to intervene or assist potential victims, but that individuals working within those agencies need to be provided with the education and tools to do so adequately. The victim in this case had been asking program workers what she could do about her situation. They had witnessed injuries on the victim, had tried to intervene and provide referrals but one worker later told police that she did not feel qualified to deal with this type of problem. Another worker did not know whether it was her job to recommend help.

Recommendation 12

To the Ministry of Community Safety & Correctional Services (MCSCS):

It is recommended the MCSCS review their current procedures for assessing risks posed by domestic violence perpetrators to assist in case planning and management and that they ensure adequate funding is in place for batterer intervention programs. (Similar to recommendations #16/2004, #17/2004, #20/2006)

Comment: The perpetrator was not identified as high risk by probation services and was on a waiting list for treatment at the time of the homicide. With all the known risk factors in this case, risk management should have been a priority. Immediate treatment was required.

Recommendation 13

To the Ministry of Community Safety & Correctional Services (MCSCS), Policing Standards Division, and the Ontario Association Chiefs of Police (OACP):

Police services across Ontario should consider implementing procedures that stipulate that when there are grounds to arrest and /or charge a person in relation to a domestic assault, and where there are public safety issues, or a delay in processing the charges, the accused should immediately be placed on the Canadian Police Information Centre (CPIC) as a Special Interest Police (SIP) entry, advising that grounds exist to arrest. *(Similar to recommendation #21/2004)*

Comment: In this case, uniformed division officers submitted a warrant application after an assault incident to the CPIC records office. It was not immediately processed and, therefore, nothing about the warrant or the grounds to arrest the accused was added to CPIC. As a result, when the accused was stopped and arrested for breaching an unrelated probation order, the officer had no knowledge of the outstanding warrant for domestic assault. If he had known, the accused would most likely have been held for a bail hearing. The homicide took place within days of his release.

OCC Files 2004-14633; 2004 14632

This case involved the homicide of a female victim and the suicide of her male acquaintance. The victim, a Canadian citizen was a single mother of three children, estranged for three years from her husband who had been deported. The perpetrator was an illegal immigrant who was unemployed, but with no criminal record in Canada. He met the victim about 5 months prior to the homicide and they began a dating relationship. Two weeks before the deaths, he moved into her apartment against her wishes, with the expectation that he would marry her.

Friends described his behaviour as possessive, and at times explosive and irrational. A close friend of the victim was adamant that the couple had never been sexually intimate, and that she had continued to resist his advances and requests for marriage. With the children present in the apartment, the perpetrator inflicted multiple sharp force injuries to his victim's neck, and then hanged himself.

No systemic issues or points of intervention were identified in this case, hence no recommendations.

OCC File No. 2005-10388

This case involved the homicide of an elderly female victim by her husband of 35 years. They had immigrated to Canada 14 years ago, and had one adult daughter who lived overseas. From all outside accounts, the couple appeared to have a normal relationship, even though the victim would usually spend 8-10 months of the year living abroad with her daughter. The perpetrator meanwhile had been carrying out a relationship with another woman unbeknownst to his wife. There were no occurrences of domestic disputes, or records of police involvement with the couple.

The victim did not return to live with her daughter at the time the perpetrator had expected. On the day of the incident, the perpetrator called 911 indicating that he could not wake is wife. Police found the death scene suspicious, and an autopsy was ordered which revealed that the cause of death was pressure to the neck with upper posterior neck trauma.

No systemic issues or points of potential intervention were identified in this case, and hence no recommendations.

OCC File No. 2003-9942

This case involved the homicide of a mature female victim by her male spouse. The victim and perpetrator had met about five years earlier, when the victim returned to her home country for a holiday after the death of her first husband. After a very short courtship they returned to Canada to live and were married. There were few outward signs of domestic strife apparent to the victim's children, who had frequent contact with the couple. However, the victim had significant alcohol abuse issues, and over a short period of time managed to deplete her financial resources completely. There were no records to indicate any concerns had been reported to physicians, other professionals, or police.

Her death was initially reported by her husband as being a result of a fall downstairs. He later acknowledged that he had been stressed by her excessive drinking and had pushed her, causing the fall.

No systemic issues or points of potential intervention were identified in this case, and hence no recommendations.

OCC File No. 2005-15314 & 2005-15313

This case involved a homicide of a female victim and suicide by her husband. The couple had been in a turbulent relationship for over eight years, with the husband leaving on several occasions. His behaviour was described as increasingly controlling, possessive and abusive. Quite frequently, the victim would confide to relatives, friends, co-workers, and her physician about her concerns and fears for her safety. Despite encouragement she refused to reach out to police or other support agencies for assistance, reportedly because of her financial dependency on her husband.

A separation occurred a few months prior to the incident when the victim demanded that her husband leave. From that point, the perpetrator, who reportedly was suffering anxiety and depression, was known to be stalking and harassing the victim. His harassment extended to her workplace and her residence. He openly discussed his frustrations, and his intent to kill his ex-wife and himself.

Police were notified of an incident about one month before the deaths, but the victim would not disclose any concerns or evidence of abuse to them. On the morning of the fatal incident, the perpetrator picked up his ex-spouse and drove her out of town. Later, both were found deceased inside a burning vehicle.

Recommendation 14

To the Ontario Women's Directorate (OWD):

It is recommended that Community agencies in partnership with Government should explore the creation of an easily accessible, non-threatening mechanism for friends and family to get information and consult with a trained individual regarding situations where they have concerns that a woman is at risk from her intimate partner. This resource could provide direction where they are not sure how to intervene and/or how to help protect the victim's safety. (Similar to recommendation #1/2006)

Comment: Many individuals involved with the victim had identified that her spouse posed some kind of risk. However, none knew how to intervene. An accessible, possibly anonymous crisis and consultation line such as a special additional line to the Assaulted Women's Helpline or Crime Stoppers could provide information or suggestions on how to support a woman to get help. Most importantly, it would provide educational feedback alerting friends and family members to high-risk indicators that might demand a more intense intervention.

Recommendation 15

To the Ontario Women's Directorate (OWD), College of Family Physicians of Canada, Ontario & Canadian Psychiatric Associations:

There must be more public education regarding the risk that suicidality poses, not only to the suicidal person but also to others involved with him/her. Within the Health Care system, men who are in relationships and who threaten or attempt suicide should consistently be screened for abusive behaviour in their relationships. Part of this screening process must involve some contact with the female partner to offer information and support regarding disclosure of abuse, services and supports available, etc.

Comment: Given the high correlation between suicidality and intimate femicides, health care practitioners, human services workers, criminal justice personnel, etc. should raise awareness of the importance of suicidality as an indicator of potential lethality.

This case in particular points to how important it is to publicize the seriousness of threats of suicide, and to provide access for community members to information and ideas regarding what actions they can take to intervene. A number of the perpetrator's friends and family were very aware of his threats of suicide, but could not find help or assistance with the situation.

Recommendation 16

To the Ministry of Community and Social Services (MCSCS), and Ontario Women's Directorate (OWD):

It is recommended that affordable housing, child care, and income support must be made available so that women trapped in abusive relationships can escape the danger as threats escalate into potentially lethal situations.

Comment: The victim in this case repeatedly voiced the concern that she could not financially afford to leave her spouse. Women experiencing abuse need to be able to escape from financial dependence and to easily access supports and services required to build a life free from the abuser. Once financial dependence is broken, women may be able to leave the abuser earlier in the troubled relationship.

OCC File No. 2003-17568

This is a case of a homicide of a 2-½ year-old victim by the same-sex partner of the child's mother. The two women had been in a relationship for about three years. The child's mother had an extensive history including alcohol and drug abuse, criminal conviction for assault, and numerous referrals to the Children's Aid Society (CAS) for suspected abuse and/or inadequate parenting skills. On every referral, the case file was closed by CAS in relatively short order.

The relationship between the perpetrator and the mother of the victim was noted to be volatile. The perpetrator was also known to be possessive, jealous, verbally and physically abusive, and controlling, keeping the mother of the victim isolated from friends and family. On the day of the incident, the victim was reported missing and later found deceased, hidden in the basement inside the home. Cause of death was given as asphyxiation and/or head trauma.

Since this case raises issues related to child abuse investigations and domestic violence it may be of assistance to reiterate the major recommendations identified by the Paediatric Death Review Committee of the Office of the Chief Coroner in its review of this case:

The PDRC highlights the larger issue in this case as being the thorough assessment of risk factors. Staffing issues in the local CAS and recording deficiencies complicated this.

The file review points to a theme that is prevalent in other death reviews; that of seeking and verifying information that the client provides. This issue must be addressed and monitored on a regular basis.

The CAS needs to ensure that training and supervision is in place to appropriately assess risk of vulnerable children, particularly after a pattern of referrals related to neglect and supervision.

The CAS must review its practices related to conducting protection investigations when parents cannot be located or are less than cooperative with intervention.

The CAS must ensure all caregivers in the home are record checked; it is unclear if this happened in this case, however it is unknown if the existence of a record would have prevented this death.

CAS interventions should focus primarily on the safety and care of children as opposed to responding to the parent's needs, particularly for young children.

Comment: The Child protection agency was made aware of a significant concern about the mother's mental health by a credible referral source. The Ministry standard would have required them to determine a response time of either 24 hours or within 7 days to see the child. Given the mother was admitted to the hospital with significant mental health concerns, a 24 hour response would have been appropriate and coordination of this response with hospital staff would have ensured that the mother was seen and assessed with a follow up plan in place to see the child. The CAS is mandated to provide after-hours emergency service to ensure timely responses to child protection referrals. Establishing contact with the mother while she was still at the hospital would have resulted in the safety assessment being properly completed as per the Ministry Standards.

Once the opportunity to undertake a direct and immediate response was lost, the erroneous contact information for the mother should have prompted the social worker to re-contact the physician to ascertain additional information. Despite the obvious problems inherent in assessing risk when a client cannot be located, greater effort to locate the mother should have been undertaken. The CAS could have advised the police of the concern reported and their inability to assess for child safety and the police could have flagged the mother's name to ensure that they advised the CAS of subsequent occurrences.

Once the mother was located, a more thorough assessment of the family circumstances should have been undertaken, given the nature of the physician referral several months earlier and the current community referral. The Ministry standard requires the social worker to complete record checks on caretakers residing with children. A record check of the mother's partner would have revealed an agency file on her as well.

A thorough assessment including verification of information being provided by the mother would have been advisable given the nature of the concerns being reported (drug use in the presence of the children, alleged unsafe living conditions). The agency had a previous record with respect to both mothers and the nature of the concerns were related to criminality, drug and alcohol abuse, emotional instability, possible neglect or lack of supervision. It would have been reasonable to open a file and complete a more thorough and comprehensive assessment that would have included determining the emotional stability of the mother over a period of time and the nature of the relationship between the two women. This would have been a reasonable response given the pattern of referrals to the agency and the age of the children. As required for the investigation and safety assessment, individual interviews with all the children should have been undertaken and collateral contacts made to verify information provided (school contacts with respect to the older children, physician etc).

Beyond these critical recommendations the DVDRC would add the following recommendations to the Ontario Association of Children's Aid Societies (OACAS), Ontario Association of Chiefs of Police (OACP), Ontario Police College (OPC), Ministry of Community Safety & Correctional Services (MCSCS) Policing Standards Division, College of Family Physicians of Canada:

Recommendation 17

It is recommended that all agencies ensure adequate training and supervision in assessing domestic violence within same-sex relationships in cases where children are involved. It is also recommended that Children's Aid Societies follow-up on a referral with all parties involved with the child or children.

Comment: A referral was made by a treating physician because of his concern over the victim's mother's mental health after she had intentionally cut her wrist with a piece of broken glass. The

CAS worker failed to make contact with the mother, and closed the file. The grandparents were also not contacted by CAS. A few months later, a referral was made to CAS by a pizza delivery person who could smell marijuana coming from the apartment when making a delivery. The CAS worker attended the home where the mother and her partner both lived and assessed the situation. The worker anticipated that relocating to a farm property would be beneficial to the couple and the worker did not assess for domestic violence.

Recommendation 18

It is recommended that social service providers, including police, physicians, and child protection services receive proper training regarding the dynamics of domestic violence in same-sex relationships.

Comment: During a serious domestic altercation between the victim's mother and her partner, where the mother used broken pieces of glass to cut her arm, police were called and had to restrain the partner while apprehending the mother under the Mental Health Act. During this incident, the police did not assess for domestic violence.

Recommendation 19

To the Ontario Women's Directorate (OWD):

It is recommended that the public be educated on the dynamics of domestic violence, including in same-sex relationships.

Comment: Many friends and family knew about the abuse that was taking place in this relationship, however because it was a same-sex relationship, friends and family may not have been as concerned as they might have been were it a more traditional heterosexual relationship.

OCC File No. 2003-13447

This case involved the homicide of a female victim and the attempted suicide of her male common-law partner. The couple had been together for over a decade in what was described as a volatile relationship. Both the victim and the perpetrator were known alcohol abusers and had frequent domestic disturbances involving dealings with police. Charges did not arise from these situations. The victim also had intermittent involvement with CAS due to concerns about her alcohol abuse and care of her child. Family counselling sessions and treatment for alcoholism had been recommended, but compliance with attendance was poor.

The perpetrator had a criminal record dating back 20 years, but as a hunter he had six firearms registered to him, as well as a crossbow. There were several instances noted in available records of physical abuse and assaults directed both at the victim and at her daughter. On a number of occasions, the perpetrator had uttered threats to shoot his partner in the head, both to her directly and to relatives and acquaintances.

In the weeks preceding the death, the victim asked the perpetrator to move out of her apartment. No neighbours, friends or family members perceived any indicators of increased risk just prior to the homicide. The victim was shot in the head with the crossbow, and the perpetrator attempted suicide, unsuccessfully, with a rifle.

Recommendation 20

To the Ontario Association of Chiefs of Police (OACP), Ontario Police College (OPC); Ministry of Community Safety & Correctional Services (MCSCS) Policing Standards Division:

It is recommended that there be ongoing training for police on the most effective response to domestic violence cases where there is a history of homicidal and suicidal threats, a recent separation, and where prior history includes domestic violence, serious substance abuse and/or child abuse. (Similar to recommendation #5/2004, #2/2005, #3/2005)

Recommendation 21

To the Ontario Association of Chiefs of Police (OACP), Ontario Police College (OPC); Ministry of Community Safety & Correctional Services (MCSCS) Policing Standards Division:

It is recommended that police services reinforce with their members the requirements of the Domestic Violence Occurrences (LE24) and Firearm Occurrences (LE029) of the Provincial Adequacy Standard Guidelines regarding the seizure of firearms during the course of Domestic Violence Occurrences. This training should be conducted on an annual basis placing emphasis on ensuring officers are appropriately educated on their authorities to conduct weapons seizures with and without a warrant. (Similar to recommendation #15/2002)

Comment: The police had several occurrence reports on file signalling potential abuse of the victim. They would also have been aware of the several firearms registered to the perpetrator. Those who knew the victim had heard her being threatened by the perpetrator on numerous prior occasions.

Recommendation 22

To the Federal Government, Department of Justice, Firearms Regulation:

It is recommended that the Federal Government revisit the Firearms Act to study the feasibility of a legislative amendment to require the registration of crossbows as restricted weapons.

Comment: There is considerable attention to the seizure of firearms as a preventative measure regarding domestic violence occurrences. Provincial Guidelines are moot to the seizure of other weapons. Although this provides some difficulty in how to characterize numerous items in a residence that could be used as weapons, at a minimum, police officers should be provided with the power to seize any item designed to be used as a weapon even though it doesn't meet the restricted or prohibited category.

Recommendation 23

To the Ontario Association of Children's Aid Societies (OACAS):

It is recommended that CAS refer cases with multiple risk factors like alleged child abuse, parental alcoholism and domestic violence to high risk case management. (Similar to recommendation #8/2004)

Recommendation 24

To the Ontario Women's Directorate (OWD):

It is recommended that OWD continue to educate the members of the public who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and provide information on practical steps that can be taken to reduce the risk for assault and lethality. (Similar to recommendation #1/2006)

Comment: Friends, family and co-workers witnessed verbal insults and threats, and on at least two occasions heard homicidal threats directed toward the victim. It would appear that no one appreciated the potential high-risk nature of the relationship or of the behaviour of the perpetrator. Aside from asking the perpetrator to move out of her apartment, the victim also did not appear to take specific actions to reduce her risk or to call on police or victim support services.

OCC File No. 2005-2100 & 2005-1022

This is a case involving a homicide of a young woman and suicide by her older spouse. The victim had become heavily involved in illicit drug and alcohol abuse, and suffered from mental health issues. Her spouse was a drug dealer involved in the urban nightclub culture, and had a criminal conviction in the past. The couple's relationship had a pattern of verbal altercations, excessive drug use, controlling behaviour by the male, and several periods of separations. During separations he would stalk and harass the victim. Reconciliation of the couple would then generally follow.

They had two small children, and there were numerous interactions with CAS due to drug-related issues, poor parenting skills, unstable environment and emotional/psycho-social neglect. About three weeks before their deaths, the couple separated again, but they still had contact with each other due to the children and custody issues. Both parents were involved in counselling, accessed through their church.

On the day of the incident, the victim attended the perpetrator's residence to pick up her children. The perpetrator shot her and shot himself.

Recommendation 25

To the Ministry of Children and Youth Services (MCYS), Child Welfare Secretariat:

It is recommended that the Ministry of Children and Youth Services through the Child Welfare Secretariat be directed to consider requiring child welfare organizations to conduct internal reviews on domestic violence deaths that occur on files open within the past 12 months where domestic violence is known to be present. Lessons learned through this process should be shared provincially for review by the Ministry of Children and Youth Services.

Comment: As we have seen in this case, Child Welfare organizations may have the most contact with families with children where domestic violence is present. The VAW/CAS Collaboration Agreements that are in place across the province direct child welfare and violence against women agencies to take specific steps and or collaborate in these cases. It is felt that the lessons learned and shared provincially from organizational internal reviews will benefit the sector and allow services to learn from these cases and implement changes to prevent further tragedies.

Recommendation 26

To the Ministry of Health and Long Term Care (MHLTC):

It is recommended that provincial Mental Health and Addictions Strategies include screening for domestic violence as a best practice. Mental health and addictions professionals who are working with women need to be provided with assessment tools that will allow them to assess and determine the level of risk. (Similar to recommendations #2/2006, #8/2005)

Comment: Several of the cases reviewed by the DVDRC have revealed that the women who present with multiple issues, including mental health and/or alcohol and drug addiction are often not screened for domestic violence or that the level of intervention regarding domestic violence is insufficient. The impact of not screening and assessing risk to self or others has resulted in missed points of intervention. Understanding the multiple and complex ways in which women experiencing domestic violence present is an essential intervention component.

OCC File No. 2004-16232 & 2005-1512

This case involved a homicide of a female victim who had been in a relatively short relationship with a male partner. Both were well educated, the victim being a physician and the perpetrator a senior policy advisor. They apparently met through an internet dating service. The victim had been in a previous abusive relationship that she had successfully extricated herself from. The perpetrator had a history of abusing a previous girlfriend, and also had a serious drug abuse problem, including heavy use of cocaine. He was described as very jealous, possessive, and had a tendency to violence.

As the perpetrator became more possessive, exhibiting an obsessive preoccupation with her whereabouts and attempting to control her life, the victim became fearful for her safety. She sought advice and assistance from professional colleagues and a confidential professional support service. Due to her professional status, she was reluctant to pursue some of the advice offered, out of fear of recognition/embarrassment.

Violent confrontations by the perpetrator escalated, with two episodes of manual strangulation of the victim, two months and then another episode about one week prior to her death. She was ultimately killed by the perpetrator in this manner. Two months later, while being held in custody for psychiatric assessment, the perpetrator hanged himself.

Recommendation 27

To Healthcare Providers:

As with Case # 2004-2221 above, it is recommended that all healthcare providers must be mindful of the dynamics of domestic violence and the potential for lethality. Where concerns may be raised for the patient's safety, an appropriate screening tool must be considered, as it may assist both the healthcare provider and the patient to better understand the lethality risks, and proactively plan appropriately for safety (i.e. calling the police, going to a shelter or safe place, meeting with a specialist in safety planning). If the patient is reluctant to take these steps on her own, she may need to be accompanied. (Similar to recommendations #2/2006, #12/2004, #7/2004)

Comment: In this case, the victim was a well-known professional woman and was reluctant to seek help from a public service where she might be identified by her colleagues and patients. The only service she felt comfortable reaching out to was an anonymous hot line for her profession. The screeners did an excellent job of referring her to local resources but given the immediate danger the patient was in, she would have benefited from an in-depth lethality assessment on the phone and education on the warning signs and escalating risk factors that she was faced with. Better understanding of the danger she was in may have lead to an increased ability on her part to take more proactive steps for her immediate safety. She was killed within two days of her phone call to the healthcare provider service.

Recommendation 28

To the Ontario Women's Directorate (OWD):

There is a continuing need to better educate family members, friends, and colleagues who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality. This is particularly important when the couple is going through a separation or the individual is showing signs of depression or suicidal or homicidal thoughts. The risk increases even further if the perpetrator has an addiction problem. (Similar to recommendations #1/2006, #1/2002, #1/2004, #3/2005)

Comment: In this case, the victim disclosed to her friends and professional colleagues that her ex-boyfriend had made two attempts to strangle her to the point that she lost consciousness. It is not clear if the significance of these potentially lethal acts was fully appreciated by all concerned.

Our Committee recognizes that while it is critical to educate the public on warning signs and risk indicators that reflect increasing danger to the victim, (i.e. strangulation attempts/choking, marks and bruises on the neck), it is not sufficient to stop there. When a victim is ambivalent about contacting the police or a Violence Against Women (VAW) advocate, or appears unwilling or incapable of acting to protect herself, then others must consider acting on her behalf.

Recommendation 29

To the Ontario Women's Directorate (OWD):

Given the high co-occurrence between addictions and domestic violence, we expand on previous recommendations to include more education for counsellors who work with clients with addiction problems who may be perpetrators of domestic violence. We recommend routine screening in every case and where there are indicators of domestic violence, we would recommend a thorough assessment of risk and risk management of the case including contact with the victim to engage in safety planning. We would not expect addiction counsellors to become experts in domestic violence work but we would recommend that they collaborate closely with the VAW sector in their community. (Similar to recommendations #7/2004, #8/2004, #5/2002)

Comment: In this case, both the victim and the perpetrator saw the primary problem as one of addiction. They both believed that if the addiction issue was resolved, then the perpetrator would no longer be controlling, jealous and abusive to the victim. Both sought help from a number of addiction services. There is no indication that either of them was screened for the presence of domestic violence.

Recommendation 30

To the Ontario Association of Chiefs of Police (OACP), Ontario Police College (OPC), Ministry of Community Safety & Correctional Services (MCSCS) Policing Services Division:

It is recommended that police officers receive additional/supplemental training, which focuses on the recognition that domestic violence does not always present itself in an obvious way, such as in a domestic violence assault, but may be imbedded in other types of criminal acts. Where domestic violence is at the root of any criminal act, the investigation must be completed within the context and application of the domestic violence policies of the respective services. Victims may be reluctant to disclose violence in their relationship, and this requires a sensitive but thorough intervention. Police must understand that reluctant victims may be at greater risk of continued violence and thereby are in greater need of proactive police response. (Similar to recommendations #4/2002, #5/2004, #23/2006, #28/2006 #25/2006)

Comment: In this case, two days prior to her murder, the victim made a 911 call to police to report a Break and Enter at her home. The victim identified her ex-boyfriend as the suspect and further indicated that he was violent. The victim also advised police that she feared retaliation as a result of calling the police. The responding police officers did not treat the occurrence as a domestic violence investigation, and simply submitted an information occurrence with no follow up or no effort to contact or investigate the suspect.

OCC File No. 2005-1468 (& other province fatality)

This case involved the homicide of a female ex-partner, attempted homicide of her new husband, and subsequent suicide by the perpetrator in another province. The victim and perpetrator had a brief, eleven-month relationship that ended almost a year before the homicide. The victim went on to establish a relationship with a new partner whom she married.

The perpetrator had previously been married for 12 years, during which time there were numerous incidents of physical assaults and abuse. Charges had been laid on various occasions, some subsequently withdrawn, and in 2003 he pled guilty to one count of assault. The relationship with his wife did not end until several months later.

During the months after his failed relationship with the victim of this case, he continued to stalk and harass her, even though she had married. He was charged with four counts of criminal harassment and one count of threatening to kill her. He was released on a recognizance with a surety who apparently did not appreciate the importance and seriousness of his responsibilities to monitor the accused.

Despite imposed conditions that he not have contact with the victim, he continued to harass her. On the date of the incident, he approached the victim and her husband in an underground garage and shot them both. Three days later the perpetrator shot himself in a hotel room while on the run from police.

Recommendation 31

To the Ministry of the Attorney General (MAG) and Ministry of Community Safety & Correctional Services (MCSCS):

It is recommended that in every domestic violence case, there be a requirement that risk be assessed. If a high-risk case is identified, it needs to be specifically red flagged for further follow up. (Similar to recommendations #10/2002, #17/2004, #27/2004)

Comment: Despite his domestic history and the fact that the perpetrator was charged with four counts of criminal harassment and one count of threatening to kill, he was apparently never identified as a high-risk offender.

Recommendation 32

To the Ministry of the Attorney General (MAG) and Ministry of Community Safety & Correctional Services (MCSCS):

It is recommended that once a case has been identified as a high risk case then there must be a systems response so that the case can be actively managed. This would require that the justice partners involved with the case meet to discuss management options and strategies. Such dedicated teams already exist in parts of Ontario and should be the model for other communities to follow. (Similar to recommendations #27/2004, #14/2002)

Comment: It would appear that despite the high risk in this case, no management response occurred to actively engage the victim and the accused so as to safeguard the victim and monitor the accused.

Recommendation 33

To the Ministry of the Attorney General (MAG) and Ministry of Community Safety & Correctional Services (MCSCS):

It is recommended that all potential sureties be required to watch an educational videotape on their role as it relates to domestic violence cases (e.g. Huron County Crown video). As well, that each police department assign a police officer to routinely call all sureties in high risk cases to check on bail compliance and the stability of the accused. (Similar to recommendations #19/2004, #20/2004)

Comment: The surety for the perpetrator did not appear to understand his responsibilities to monitor the activities and whereabouts of his charge. His knowledge of English was limited, and he apparently did not know how to contact police urgently when the perpetrator left his house and had not been seen for two days.

Inquest into the deaths of Lori Dupont and Marc Daniel

This case involved the homicide of a female victim by her former male partner, and his suicide. These deaths were the subject of a major inquest held September 24 to December 11, 2007. Please refer to **Appendix "C"** for the presiding coroner's explanation of the details of the circumstances, as well as the jury's verdict and recommendations. Because of the inquest, the DVDRC did not formally review the case, but the Committee has analyzed the identifiable risk factors and included the deaths in our statistical database.

Chapter Four
Major Themes from Recommendations

Over the past five years, the Committee has made numerous recommendations aimed at preventing domestic homicides. Each case that the Committee reviews can provide insights into how such incidents can be avoided. The Committee has noted that several recommendations from past reports continue to have relevance for new cases being reviewed. Table 1 illustrates the frequency of recommendations made by the Committee in past years.

Table 1- Frequency of Themes in DVDRC Recommendations from 2003-2007

	2007 Recommendations	2003-2006 Recommendations	Total Number of Rec.
Awareness and Education	**18**	**50**	**68**
Education and Awareness to the general public and professionals	8	36	43
Enhanced Training of Professionals	9	7	14
Systems of Education (including elementary, high school, college, universities, and graduate programs)	1	7	8
Assessment and Intervention	**13**	**41**	**54**
Risk Assessment Tools	2	5	7
Safety Planning/Shelters	1	3	4
High-risk Cases and Case Management	1	5	5
Police Interventions	1	9	10
Crown/Court Interventions	1	3	3
Workplace Interventions	3	3	3
Healthcare and Social Services Interventions	2	10	11
Access and Control of Firearms	2	3	5
Resources	**2**	**5**	**7**
General Resources	1	3	4
Rural/First Nation Communities	1	1	2
Resources for Homicide and Suicide Investigations	-	1	1
Child-Related Issues	**2**	**10**	**12**
Legislation	-	3	3
Assessment	-	5	5
Policy and Practice in dealing with domestic violence, children and custody, and/or access disputes	2	1	3
Public Awareness of Child Abuse	-	1	1

A theme that we have seen consistently raised is the importance of educating and training professionals that come into contact with victims and/or perpetrators of domestic violence. In this review period, the Committee reviewed six cases where professionals, having had contact with either the victim or the perpetrator, failed to address the issue of possible abuse within the relationship. In some cases, the ability to identify abuse was difficult because it was masked by factors such as addiction, suicidal thoughts, and depression. It is important that professionals are trained to recognize the presence of domestic violence even when it may not be the presenting problem. Training is especially important for professionals working in rural and remote communities due to service limitations in those areas.

It is also important that all professionals, including those in child-protection services, health care services, police, lawyers, religious leaders, and individuals in different systems of education, understand and recognize the risk factors for potential lethality in an intimate relationship, and that the level of risk is identified for the victim and dealt with appropriately. For example, the threat of suicide or suicidal thoughts can indicate a high risk, not only to the person who is suicidal, but also to others involved with that individual. In six of the cases the Committee reviewed, the perpetrator disclosed suicidal thoughts and/or severe depression prior to the homicide.

Another common theme stemming from the Committee's past reviews is the need to educate the public about the dynamics of domestic violence and provide information on practical steps that can be taken to reduce the risk for lethality. In many cases, family members, friends, acquaintances, and co-workers of the perpetrator and/or the victim were aware of the abuse occurring in the relationship, but were unaware of what they could do to prevent the abuse from escalating. It is clearly difficult to intervene appropriately and effectively with victims or perpetrators of domestic violence without having the knowledge of how to proceed. In the past, the Committee has made recommendations to create education campaigns that inform the public about the dynamics of domestic violence. Several communities have responded (see Chapter 5). Work in this area needs to continue in order to raise awareness of domestic violence and the risks for lethality.

A theme emerging from this year's recommendations is the importance of screening, treating, and monitoring men suffering with depression and/or suicidal ideation. Similar to last year's report, a significant risk factor found in perpetrators of domestic homicide was the presence of depression. In 65% of all reviewed cases from 2003 to 2007, the perpetrator was considered to be depressed in the opinions of family members, friends, etc. Research has indicated that there is a relationship between male depression and domestic homicide and homicide/suicide. The Committee has made recommendations to educate both the public and professionals on the risk of suicide in the context of domestic violence, and has recommended that professionals screen men experiencing depression for abusive behaviour in their intimate relationships. The Oklahoma Domestic Violence Fatality Review Board published a paper in their 2005 report that illustrates how mental-health practitioners can screen patients for domestic violence when they present symptoms of depression and/or suicidal thoughts.[9]

There were several recommendations made by the Committee this year regarding domestic violence in the workplace. It is not uncommon that domestic violence can extend from the home into the workplace with the perpetrator harassing the victim by showing up unannounced, by calling repeatedly, or by forcing the victim to be late or absent from work. Moreover, the perpetrator may work with the victim and continuously harass and assault the victim on the job site.

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[9] Sullivan, J. (2005). Mental health Response. Domestic Violence Homicide in Oklahoma: A Report of the Oklahoma Domestic Violence Fatality Review Board 2005. Retrieved March 13, 2007 from http://www.ocjrc.net/pubFiles/DVFRB/AnnualReport2005.pdf.

It is important that co-workers, human resource managers, and employers understand the negative impact of domestic violence and workplace harassment, as well as their potential role in protecting their employees from it. Several of the recommendations made by the Committee addressed the need for workplaces to design and implement policies that address domestic violence and harassment in the workplace and how to enforce these policies when claims of misconduct are present. All employees should receive extensive training about the dynamics of domestic violence and workplace harassment so that they are equipped to deal with these circumstances appropriately and effectively when they occur.

Chapter Five
The Continuing Evolution of Community Responses to Domestic Violence in Ontario

In the 2006 Annual Report, the DVDRC presented several encouraging examples of programs, campaigns, collaborations, and legislation that may have been created in part in response to recommendations made by the committee. Due to the requests from participants at the Learning from Domestic Violence Tragedies conference held in Toronto and London in September 2007 for continuing collaboration and education on resources, the Committee feels it is helpful to continue to inform the public of the significant progress that has made in the province thus far. Further details concerning any of these programs or initiatives may be obtained by contacting the appropriate agency or website.

Enhanced Training of Professionals

A common theme that continues to surface is the need for extensive training of professionals in identifying and responding to risk factors for domestic homicide. Often, professionals come into contact with victims and/or perpetrators of domestic violence and fail to recognize and/or respond to identifiable risks of lethality within the intimate relationship. Table 1 illustrates the frequency of these interactions.

Table 1 – % of cases that had professionals involved with either the victim and/or the perpetrator

Mental Health & Counselling	Police	Courts	Medical	DV Treatment (e.g. shelter, group counselling, PAR program)	Child Protection Services	Clergy
65%	43%	27%	23%	22%	18%	5%

Due to limitations in available documentation, these statistics may under-represent the actual percentages. The data suggests that there may be many potential opportunities to assess and respond to domestic abuse that may be occurring. Enhanced training and education of these professionals and agencies would assist in identifying and responding appropriately to domestic abuse. Fortunately, several professions have addressed this need for enhanced training and have created innovative programs.

Emergency Medical Services and Emergency Department staff are often the first health-care providers to encounter victims of abuse, yet some may not know how to identify victims and others at risk for serious injury. Emergency health providers may be uncomfortable asking about abuse, or may be uncertain about the appropriate referrals and resources available for women wanting additional help or support. An apparent need exists to provide enhanced training to this sector.

> In response to this need, and consistent with the recommendations of the Domestic Violence Death Review Committee, the province of Ontario funded projects to develop curricula specifically for these health-care providers. The Emergency Department Response to Domestic Violence was developed by experts with input from over 65 stakeholders throughout the province. It is composed of web-based programs for self-education on domestic violence, utilizing video game platforms and interactive scenarios. Physicians and nurses participating in this training are eligible for continuing education credits through their respective Colleges. For information on this program please contact www.dveducation.ca. It is free to Ontario participants.

Public Awareness and Education

Another theme that consistently arises from Committee reviews is the importance of public awareness about domestic violence and the potential for lethality. Table 2 illustrates the frequency with which individuals close to the victim and/or perpetrators were aware that domestic abuse was occurring.

Table 2 - % of cases, which reported certain people were aware of the abuse occurring

Family	Friends	Neighbours	Co-Workers
75%	58%	20%	17%

Due to review limitations these statistics may also under-represent the actual percentages. Nevertheless, the data suggests that individuals who knew the victim and/or the perpetrator missed signs indicating the potential for lethality, or did not know how to effectively intervene. The need for public awareness and education on recognizing the signs of domestic violence, and knowing how to appropriately intervene, is crucial to the safety of many women and children.

The Ontario Women's Directorate runs a campaign called Neighbours, Friends and Family (NFF) that addresses this need for public awareness and education. It was developed to provide educational materials about domestic violence to the public and to provide strategies for effectively intervening in the hopes of providing enhanced safety to women and children at risk. This campaign has also responded to the Committee's recommendations for training and education about domestic violence in the workplace. Workshops arranged by the NFF campaign, funded by the Ontario Victim Services Secretariat have shown that they are having the desired educational and awareness impact on the participants, increasing their ability to identify risk factors for domestic violence and their ability to provide referrals.

One of the components of the workshops presented by the NFF campaign was an interactive forum theatre production titled 'Missed Opportunities', which is also available on DVD, that depicts a family dealing with abuse and serves to illustrate many missed opportunities for bystanders to intervene. Information on the Neighbours, Friends and Family program can be accessed through www.neighboursfriendsandfamily.ca.

Awareness and Education for Youth

In 2006, seven cases of domestic homicide in Ontario involved child victims. Several more cases had children/teenagers that witnessed domestic violence or experienced violence in dating relationships. It is important that children are educated about the dynamics of domestic violence and know where to go for help. Programs and campaigns have been developed with the purpose of educating youth about domestic violence and the risk for lethality.

Nishnawbe-Aski Nation is an Aboriginal political organization that represents 49 First Nation communities. The Nishnawbe-Aski Nation Decade for Youth Council created the Decade Girl Power! program for Aboriginal girls. This program was created to raise awareness about relevant issues in a young woman's life with the goal of promoting positive self-esteem, eliminating discrimination, and preventing violence against women including sexual harassment, date rape, and domestic violence. For further information on the program and how to launch a 'Girl Power program' in your community, please visit www.nandecade.ca/article/girl-power-resources-97.asp.

Family Service a la famille Ottawa, the Ottawa-Carleton Catholic School Board, and the Ottawa-Carleton District School Board have launched a collaborative educational program titled 'In Love...and In Danger.' This program was developed in response to the increase in violence in dating relationships among teenagers and the tragic deaths of young teenage women at the hands of their abusive partners. This is an innovative youth centred anti-violence campaign that encourages youth to collect information and create strategies and projects designed to educate their peers. For further information on this program, please visit http://www.familyservicesottawa.org/english/ilid.html.

Innovative Interventions

The main themes of this year's recommendations by the Committee are training of professionals, public awareness, the risks associated with male depression, and domestic violence in the workplace. The Committee has previously made several recommendations concerning the need for effective interventions with victims and perpetrators of domestic violence. There have been several recent innovative intervention strategies created in response to the Committee's recommendations.

The Bail Safety Project is an Ontario Government initiative that was created to help identify high-risk perpetrators by conducting in-depth interviews with the victims of domestic violence at the bail stage of proceedings, with the hope of keeping high-risk victims of domestic violence safe from further violence. It has been implemented in 10 locations across the province. By gaining important information from the victims, the Crown prosecutors are better able to make recommendations for strict conditions at bail hearings that will minimize the risk posed by the perpetrator to the victim.

In 2006, the Region of Waterloo implemented the Family Violence Project (FVP) to provide support for victims and their families through 11 different agencies and support services partnered in a single facility at one centralized location. Victims and their families can receive crisis counselling, counselling for domestic violence or sexual assault, and financial counselling from trained professionals. Police officers and attorneys are available to provide information on legal and court processes, and victim/witness services help with safety planning and connecting victims to local shelters. For further information, please visit www.fvpwaterloo.ca.

Appendix A

DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE (DVDRC) TERMS OF REFERENCE

Purpose:

The purpose of this committee is to assist the Office of the Chief Coroner in the investigation and review of deaths of persons that occur as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances.

Definition of Domestic Violence Deaths:

All homicides that involve the death of a person, and/or his child(ren) committed by the person's partner or ex-partner from an intimate relationship.

Objectives:

1. To provide and coordinate a confidential multi-disciplinary review of domestic violence deaths pursuant to Section 15(4) of the Coroners Act, R.S.O. 1990, Chapter c. 37, as amended.

2. To offer expert opinion to the Chief Coroner regarding the circumstances of the event leading to the death in the individual cases reviewed.

3. To create and maintain a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances.

4. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.

5. To help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies.

6. To conduct and promote research where appropriate.

7. To stimulate educational activities through the recognition of systemic issues or problems and/or:
   - referral to appropriate agencies for action;
   - where appropriate, assist in the development of protocols with a view to prevention;
   - where appropriate, disseminate educational information.

8. To report annually to the Chief Coroner the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews.

Note: All of the above described objectives and attendant committee activities are subject to the limitations imposed by the Coroners Act of Ontario Section 18(2) and the Freedom of Information and Protection of Privacy Act.

Appendix B

Ontario Domestic Violence Death Review Committee
Risk Factor Coding Form

(see descriptors below)

A= Evidence suggests that the risk factor was not present
P= Evidence suggests that the risk factor was present
Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor	Code (P,A, Unk)
1. History of violence outside of the family by perpetrator*	
2. History of domestic violence	
3. Prior threats to kill victim	
4. Prior threats with a weapon*	
5. Prior assault with a weapon*	
6. Prior threats to commit suicide by perpetrator*	
7. Prior suicide attempts by perpetrator*	
8. Prior attempts to isolate the victim	
9. Controlled most or all of victim's daily activities	
10. Prior hostage-taking and/or forcible confinement	
11. Prior forced sexual acts and/or assaults during sex	
12. Child custody or access disputes	
13. Prior destruction or deprivation of victim's property	
14. Prior violence against family pets	
15. Prior assault on victim while pregnant	
16. Choked victim in the past	
17. Perpetrator was abused and/or witnessed domestic violence as a child	
18. Escalation of violence	
19. Obsessive behaviour displayed by perpetrator	
20. Perpetrator unemployed	
21. Victim and perpetrator living common-law	
22. Presence of stepchildren in the home	
23. Extreme minimization and/or denial of spousal assault history	
24. Actual or pending separation	
25. Excessive alcohol and/or drug use by perpetrator*	
26. Severe and excessive alcohol and/or drug use by perpetrator*	
27. Depression – family/friend/acquaintance opinion - perpetrator*	
28. Depression – professionally diagnosed – perpetrator*	
29. Other mental health or psychiatric problems – perpetrator	
30. Access to or possession of any firearms	
31. New partner in victim's life	
32. Failure to comply with authority – perpetrator*	
33. Perpetrator exposed to/witnessed suicidal behaviour in family of origin*	
34. After risk assessment, perpetrator had access to victim*	
35. Youth of couple	
Other factors that increased risk in this case? Specify: _____	

* = Revised or new item

Risk Factor Descriptions

Perpetrator = The primary aggressor in the relationship
Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

1. Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
2. Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
3. Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."
4. Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
5. Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
6. Any act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("I'm going away"). Acts can include, for example, giving away prized possessions.
7. Any actual suicidal behaviour (e.g., swallowing pills; holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.
8. Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").
9. Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).

10. Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
11. Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
12. Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
13. Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
14. Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
15. Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
16. Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
17. As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
19. Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
20. Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.
21. The victim and perpetrator were cohabiting.
22. Any child(ren) that is(are) not biologically related to the perpetrator.
23. At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).
24. The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.

25. Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. Please include comments by family, friends, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.
26. Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that substantially impaired the perpetrator's health or social functioning (e.g., resulted in an overdose, or job loss, or arrest, etc.).
27. In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
28. A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner), regardless of whether or not the perpetrator received treatment.
29. For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.
30. The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.
31. There was a new intimate partner in the victim's life.
32. The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.
33. As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.
34. After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.
35. Victim and perpetrator were between the ages of 15 and 24.

Appendix C

Verdict Explanation

Lori Dupont and Marc Daniel Inquest

September 24 – October 18, 2007
Ciociaro Club, Windsor, ON
October 29-November 1, 2007
Hellenic Club, Windsor, ON
November 5-15, 2007
Ciociaro Club, Windsor, ON
November 19-21, 2007
Hellenic Club, Windsor, ON
November 26-29, December 3-4, 11, 2007
Ciociaro Club, Windsor, ON

I intend to give a brief synopsis of issues presented at this inquest.

I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and recommendations of the jury and is not intended to be considered as actual evidence presented at the inquest. It is in no way intended to replace the jury's verdict.

PARTICIPANTS:

Counsel to the Coroner:	Mr. Eric Siebenmorgen Chief Counsel Office of the Chief Coroner for Ontario 26 Grenville Street Toronto, ON M7A 2G9
Investigating Officer:	D/Sgt. Scott Boulton D/Cst. Dave Maddocks Ontario Provincial Police
Coroner's Constable:	*Cst. Adoree Fleming* Ontario Provincial Police
Court Reporter:	Loretta Dekold, Ontario Court of Justice Windsor, ON (519) 973-6600 ext 4102
Parties with standing:	Represented By:
1. Family of Lori Dupont	Mr. Greg Monforton and Ms. Ruth Stewart Greg Monforton and Partners

	100 Ouellette Avenue, 13th Flr Windsor, ON N9A 6T3
2. Family of Marc Daniel	Mr. Robert Matlack 739 Walker Road, Windsor, ON N8Y 2N2
3. Ontario Nurses Association	Ms. Elizabeth McIntyre and Ms. Janina Fogels Callalluzzo Hayes Shilton McIntyre & Cornish 474 Bathurst Street, Suite 300 Toronto, ON M5T 2S6
4. Hotel Dieu Grace Hospital	Mr. Patrick Ducharme Ducharme Fox LLP 800 University West Ave. Windsor, ON N9A 5R9
5. Crown Attorney's Office of Windsor	Mr. Troy Harrison and Mr. John Zarudny Ministry of the Attorney General 720 Bay Street, 8th floor Toronto, ON M5G 2K1
6. Ministry of Labour	Mr. Bruce Arnott Ministry of Labour 400 University Avenue, 7th Floor Toronto, ON M7A 1T7
7. Drs. Burke, Taylor and Arya	Ms. Jennifer McKendry and Ms. Lisa Bonin McCarthy Tétrault LLP Box 48, Suite 4700, Toronto Dominion Bank Tower Toronto, ON M5K 1E6
8. Ontario Hospital Association	Mr. John Morris and Ms. Nyranne Martin Borden Ladner Gervais LLP Scotia Plaza 40 King Street West Toronto, Ontario, Canada M5H 3Y4
9. Ms. Tammy Fryer-Dougan	Mr. Dan Scott 380 Ouellette Ave Suite 302 Windsor, ON N9A 6X5

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

The jury heard the testimony of fifty-one witnesses over the course of the inquest. There were one hundred and seventy six exhibits entered in evidence. There were 34 days of testimony, one day of submissions by counsel, one day for the coroner to charge the jury and a final day for the jury to deliver their verdict.

Evidence was heard that Lori Dupont, a recovery room nurse at Hotel Dieu Grace Hospital (HDGH) in Windsor, and Marc Daniel, an anaesthesiologist at the same hospital, were involved in an intimate relationship that had begun sometime in 2004, after Dr. Daniel separated from his wife. Several witnesses indicated that Dr. Daniel pursued Ms. Dupont and pressed her first to have a relationship with him, and then to allow him to move into the house that Ms. Dupont had purchased for herself and her daughter. He provided funds to finance the largest portion of the purchase price.

Various witnesses testified that Dr. Daniel was involved in various disputes and altercations at work before and during this time. He had verbal disputes with co-workers and with the nurse manager of the operating room and recovery room. A nurse's finger was broken when he wrestled a pillow out of her hands (pillows were apparently viewed by him as essential equipment for inducing anaesthesia). A nurse had made a written complaint after Dr. Daniel excluded her from the operating room he was working in, but this case had not been resolved by the time of the deaths some sixteen months later. The nurse manager had filed a written complaint regarding abusive language directed at her by Dr. Daniel. This had resulted in Dr. Daniel being investigated by the hospital. After negotiation with Dr. Daniel and his counsel, Dr. Daniel signed a Memorandum of Agreement whereby he was placed on probation in January 2005, agreed to abide by the hospital's Code of Conduct and workplace harassment policy, and was required to undergo anger management therapy.

On February 27, 2005 Dr. Daniel attempted suicide using intravenous drugs commonly used to induce anaesthesia. He did this in the presence of Lori Dupont, and a statement of Lori Dupont's filed as an exhibit contained information that he told her that she had "done this to him". Several witnesses testified that Dr. Daniel had previously and repeatedly used the threat of suicide to control Ms. Dupont. Ms. Dupont and her mother performed CPR on Dr. Daniel, and he was transported to HDGH where he was admitted and treated. He was initially in the ICU and then involuntarily admitted to the acute psychiatric ward. Nurses and the physicians who treated Dr. Daniel testified that he told them that pressures at work had led to his suicide attempt. However, both Lori Dupont and her mother were recorded as having called the unit to advise the staff that Dr. Daniel was not telling the truth about the reason behind the suicide attempt and that, in fact, he made the attempt to try to control Ms. Dupont who was not following his wishes that she not leave the house to go shopping. Further, Ms. Dupont's mother advised that she feared for her granddaughter's and daughter's physical safety. Barbara Dupont spoke with Dr. Daniel and informed him that he would not be allowed to contact her daughter in the future. Ms. Dupont informed Dr. Daniel that the relationship was over at that point.

On March 10, 2005, Dr. Daniel was discharged from the HDGH's psychiatric ward. His care was transferred at his request from the initial treating psychiatrist to another psychiatrist. He also began psychotherapy with a psychologist. This psychologist was the only witness who testified that she viewed Dr. Daniel's suicide attempt as an aggressive act.

During the initial days after discharge, Dr. Daniel repeatedly attempted to contact Lori Dupont. Witnesses stated that he was observed attending in the operating room and recovery room area, even though he was on medical leave and that he appeared to be watching Ms. Dupont. Ms. Dupont's parents interceded to prevent him contacting her. On or about April 5, 2005, Dr. Daniel placed a potentially embarrassing photograph of Ms. Dupont on her windshield according to witnesses. Apparently, no other person in the workplace viewed this photograph, but its contents

were sufficiently embarrassing to Ms. Dupont that she was upset by his threat to distribute it. Dr. Daniel also met with Ms. Dupont's father at his place of work and made a further threat to distribute the picture unless all funds he stated were owed (from the house purchase) to him were returned. On April 8, 2005, Ms. Dupont attended a meeting of security, supervisory and legal personnel at the hospital at their request to discuss what action ought to be taken in light of this act by Dr. Daniel. Witnesses testified that Ms. Dupont was a very private person who simply wanted Dr. Daniel to leave her alone so that she could continue without him. As a result of that meeting, Ms. Dupont sought a peace bond, but this was repeatedly delayed, and in fact, the final hearing was not scheduled until some weeks after her death. The hospital cancelled his security card access and asked him to get his psychotherapy and pick up his mail elsewhere, which he agreed through his counsel to do.

During this period, the Physicians Health Program (PHP) of the Ontario Medical Association became involved after Ms. Dupont and a colleague of Dr. Daniel notified them. The Physicians Health Program provided a contract for Dr. Daniel specifying certain information could be shared with workplace monitors and his psychiatrist, among others. However, his psychiatrist did not receive information from the workplace, and he testified that he was not aware of the extent of Dr. Daniel's behaviour in the workplace. Further, it appeared that Dr. Daniel notified the psychiatrist of his readiness to return to work, and that the psychiatrist then wrote to the Physicians Health Program, which in turn accepted that Dr. Daniel was ready to work. The hospital was notified of this by the PHP, and Dr. Daniel returned to work without the input of nursing staff and Ms. Dupont. The treating psychiatrist and psychologist testified that they were bound to respect Dr. Daniel's confidentiality and therefore could not seek corroborating or independent information on his progress or accept unsolicited information as they said that to do so would acknowledge that they were treating Dr. Daniel, which would itself be a breach of confidentiality. The jury heard a repeated theme from the mental health professionals that the bounds of confidentiality prevented them from getting a 360-degree assessment of Dr. Daniel.

Dr. Daniel returned to work at the beginning of June and almost immediately there began to be incidents of problematic behaviour on his part. Evidence was heard that he kissed a nurse on the cheek and offered to rub the naked back of another nurse. Further, staff began to be concerned about his staring at Lori Dupont in the Recovery Room when he brought patients there after cases. Witnesses testified that other nursing staff would band around the bed when Ms. Dupont received a patient from Dr. Daniel in order to shield her from his intense stares. Staff became concerned that he would "go postal". He continued to have a dispute with the nurse who had been excluded from his operating room and also with the nurse manager. He would go to the nurses' lunchroom and stare at Ms. Dupont. One witness testified that he "body checked" Ms. Dupont as they passed each other in the hallway one day.

Ms. Dupont apparently met with the nurse manager in the area but the nurse manager testified that Ms. Dupont told her that she was handling the situation. This witness again referred to Ms. Dupont's desire for privacy. Further, a number of witnesses testified that Ms. Dupont was urged by hospital management to make a written complaint, which she did not do, perhaps due to embarrassment. These witnesses stated that they believed the hospital would not act without a written complaint about Dr. Daniel's harassment.

During the period before and after Dr. Daniel's return to work, there was a financial dispute between Ms. Dupont and Dr. Daniel over the funds that he had provided towards the purchase of a house. Ms. Dupont had returned the funds but retained a percentage thereof because of the hardship she and her family believed she had endured as a consequence of Dr. Daniel's behaviour.

The jury also heard testimony from two sisters who were friends of Lori Dupont. One of the sisters worked at HDGH and in early June 2005 she approached the hospital risk manager who is also a lawyer to express her and her sister's concern for the way in which Dr. Daniel had returned to work and the effect that his behaviour had on Ms. Dupont. She testified that the risk manager had

said that it was difficult to remove a doctor's privileges. The risk manager disputed this version in her testimony, stating that she had not read the detailed email sent by the sister, nor did she know the full extent of the concerns.

A number of hospital witnesses were asked why Dr. Daniel's contraventions of the Memorandum of Agreement after his return to work in June 2005 did not lead to further action on the part of the hospital. The hospital's Chief of Staff testified that he viewed Dr. Daniel as ill and the behaviour as a symptom of his illness, and he thus wanted treatment for Dr. Daniel as opposed to discipline. No other explanation was offered by any other witness.

The case manager for the Physicians Health Program testified that the week prior to the deaths, Dr. Daniel met with her and spoke obsessively about Ms. Dupont. This concerned her and she asked the psychologist to reassess Dr. Daniel. Unfortunately, the deaths occurred before this could be done.

A number of witnesses were questioned about what action they had taken regarding Dr. Daniel's behaviour after February 2005. No evidence was given that any official from the hospital or elsewhere confronted Dr. Daniel concerning his behaviour toward Ms. Dupont. Aside from a request by Ms. Dupont's father that the Amherstburg police increase their patrols by her house, no person contacted a police agency about his behaviour toward Ms. Dupont.

On Saturday, November 12, 2005, Lori Dupont and Marc Daniel were scheduled to work together. At about 9:00 am, Ms. Dupont was in the Recovery Room getting equipment ready for the day. Dr. Daniel came into the room and spoke with a co-worker of Ms. Dupont. The co-worker turned away and then heard screams. She turned back and observed Dr. Daniel stabbing Ms. Dupont. Dr. Daniel then exited the hospital, and was observed on surveillance video leaving the hospital in his car. Despite a heroic resuscitation attempt by the operating and recovery room staff, which included a cardiothoracic surgeon, Ms. Dupont could not be resuscitated.

Dr. Daniel called his wife on his cellular phone and told her he had killed Ms. Dupont. He told his wife that he was going to kill himself. His vehicle was tracked to the Windsor waterfront. The Windsor police approached the car using a tactical approach due to the unknown danger presented by Dr. Daniel. When they got close to the car, they observed Dr. Daniel unresponsive (he was, in fact, vital signs absent) in the car. He was aggressively resuscitated by paramedics and had a return of vital signs. However, he died three days later in the ICU at London Health Sciences Centre.

The jury heard the testimony of three expert witnesses. The first two, a physician who is a senior executive in an Ontario hospital and a lawyer who specializes in physician privilege issues provided an expert report and also testified as a panel. These experts testified that the current legislation governing physicians' privileges in Ontario hospitals, the Public Hospitals Act, could be simplified with the benefit of allowing hospitals to deal with problematic physicians more expeditiously. Based on the principle that justice delayed is justice denied, physicians would also benefit because formerly lengthy proceedings requiring a hearing before the Medical Advisory Committee, the hospital Board and potentially the Health Professionals Appeal and Review Board would be truncated. These experts recommended adopting a simpler format for dealing with physician privilege issues. They recommended that once a decision has been made by the hospital to limit, alter, suspend or revoke a physician's hospital privileges, any appeal should be made directly to an external tribunal specifically formed to deal independently with privilege matters.

The senior executive physician recommended the adoption of the Disruptive Physician Behaviour Initiative approach of the College of Physicians and Surgeons of Ontario as a means of dealing with a disruptive physician, along with enforcement of a code of conduct, and addressing behavioural issues during the initial application process and at the annual re-application process. He further recommended that probationary status for physicians be defined in hospital By-Laws,

which should define the specific roles and responsibilities of the Chief of the Medical Staff and medical Department Chiefs with respect to dealing with disruptive physicians. Further, he recommended extensive changes to the Public Hospitals Act to allow early identification and management of disruptive physicians, as well as a requirement for a probationary status for physicians. He recommended that suspension of an alleged seriously disruptive physician's hospital privileges should continue until the ultimate hearing. He recommended that the Physician Health Program have a standard template for reporting to them on physicians that they are monitoring, and that the PHP do a 360 degree evaluation prior to a physician's return to work.

This witness also gave testimony in which he stated that the "picture incident" in April 2005 was a "sentinel event". He testified that a similar incident should result in definitive action to ensure the safety of staff and the competence of the physician. He also stated that it was his view as both a senior executive physician and an anaesthesiologist that a hospital should fully investigate when drugs potentially taken from the hospital are misused, as was the case with Dr. Daniel's February 2005 suicide attempt.

The final expert witness was an expert in domestic violence. His comprehensive expert report was provided to the jury as an exhibit. He testified that a worker who is off work due to behavioural or mental issues should not be allowed to return to work until a full assessment of fitness to return is done. This assessment, he testified, should include seeking the consent of the worker at the outset of therapy to obtain information about the worker from peers, subordinates and supervisors at work as well as from the worker. In this case, the evidence was that the only information that the therapists had about Dr. Daniel and his state of mind at the time he returned to work was from Dr. Daniel himself. After Dr. Daniel had been back at work, there was virtually no information about his increasingly problematic behaviours given to the PHP or his therapists until several days before the deaths.

The domestic violence expert also testified that there are a number of factors associated with the risk of lethal domestic violence. In hindsight, Dr. Daniel exhibited the majority of these, most notably, clinical depression, suicide attempt and recent separation from his domestic partner. This expert testified that it is important to put boundaries on the behaviour of individuals such as Dr. Daniel, and that there must be consequences to the repeated violation of agreements such as the one signed by Dr. Daniel and the hospital. Also, the expert testified under cross examination that assessment of the potential for violence and the fitness of the client to return to work is intrinsic to treatment, and cannot be artificially separated. Finally, in response to a question from the jury, he testified that for a patient to be treated for significant mental health issues at his own hospital might represent a conflict of interest; he stated that it would be better for the treatment to be undertaken by a third-party institution and therapist.

In the opinion of this expert, victims of domestic abuse such as Ms. Dupont are often reticent to complain. The expert testified that employers and others must be sensitive to this reticence and not place the onus on the victim to pursue the perpetrator. He stated that investigation of abuse and verbal harassment should be added to the current Ministry of Labour role to investigate workplace violence. Mediation, such as was attempted between Dr. Daniel and the nurse with whom he had a dispute, should not be used where there is a significant power imbalance.

This expert was questioned about the effect of mental illness on Dr. Daniel's behaviour. He testified that even if the problematic behaviour of a person was due to mental illness, the behaviour itself could not be allowed to harm other individuals. He also testified that if a person were incompetent due to a mental disorder and harming either himself or others, then the Mental Health Act would come into play. However, he made the point that a mentally ill person may be competent and thus responsible for his or her actions, including harming, harassing or threatening others.

Verdict:

1.	Name of deceased Nom du (de la) défunt(e)	*Lori Arline Dupont*
2.	Date and time of death Date et heure she he du décès	*Nov. 12, 2005, 9:27am*
3.	Place of Death Lieu de décès	*Hotel-Dieu Grace Hospital, Windsor, Ontario*
4.	Cause of death Cause du décès	*Bleeding due to multiple stab wounds to the chest.*
5.	By what means	*Homicide*

1.	Name of deceased Nom du (de la) défunt(e)	*Marc Daniel*
2.	Date and time of death Date et heure du décès	*Nov. 15, 2005, 3:44am*
3.	Place of Death Lieu de décès	*London Health Sciences Centre, Victoria Campus London, Ontario*
4.	Cause of death Cause du décès	*Anoxic ischemic encephalopathy and bronchopneumonia due to Midazolam toxicity*
5.	By what means	*Suicide*

Dupont / Daniel Inquest

OPENING STATEMENT

The jury wishes to express sincere condolences to the family of Lori Dupont and to the family of Marc Daniel. We also recognize the profound effect that this tragedy has had on the Hotel-Dieu Grace Hospital and this entire community.

Rest assured that throughout these proceedings, this jury has taken its' responsibilities seriously and acted diligently with the charge of making recommendations that will hopefully save lives in the future with regards to domestic and workplace violence.

JURY RECOMMENDATIONS

TO THE LEGISLATURE OF ONTARIO and THE MINISTRY OF HEALTH AND LONG TERM CARE:

1. There should be a review, conducted on a priority basis, of the *Public Hospitals Act* (PHA) with a view to examining the hospital-physician relationship to ensure safety and quality of care in hospitals. This detailed review should involve various stakeholders, including but not limited to: the Ontario Hospital Association, the Ontario Nurses

Association, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario (CPSO), and should have the goal of ensuring and promoting the safety of staff and patients as well as quality of care in Ontario's public hospitals. The following principles and considerations, raised by the evidence at this inquest, should be addressed:

2. Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superceded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.

3. Review the parameters for the approval of credentialing applications and for re-appointments to the medical staff.

4. Develop a process or mechanism for the early identification of and response to Disruptive Physician Behaviour, including timely and effective disciplinary actions.

5. Simplify the process for non-approval of re-appointment, immediate suspension or revocation of Hospital privileges and for the initiation of probationary status.

6. Following an investigation by a Hospital Board or Medical Advisory Committee regarding serious complaints, including disruptive physician behaviour, affecting quality of patient care and / or patient and staff safety, non-approval of re-appointment, immediate revocation, suspension and initiation of probation status should be implemented.

7. The current system of repetitive hearings should be eliminated and replaced by a streamlined system whereby physicians have an opportunity for an immediate hearing before an external tribunal (independent of the Hospital) following a decision by the relevant decision maker at the Hospital level. The decision following such a hearing may be appealed at the Divisional Court.

8. Make available to hospitals the services of an "ombudsman" who would have the power to receive complaints about physicians, conduct investigations, report back as appropriate, and grant remedies.

9. The requirement of mandatory reporting to the CPSO in section 33 of the PHA should be reconciled with the reporting obligation in section 85.5 of the *Regulated Health Professions Act* (RHPA) and should include reporting for physicians who have been placed on probationary status and/or have had their privileges restricted/reduced during an investigation.

10. The PHA should (either through the Act itself or through enabling Regulation governing hospital by-laws) explicitly recognize the application of the Occupational Health and Safety Act (OHSA) and the Ontario Human Rights Code (OHRC) to physicians with privileges at public hospitals when the behaviour of physicians negatively impacts on the staff of the hospital.

Rationale: Despite significant and documented complaints of serious disruptive behaviour problems and infractions of the Hospital Policies and by-laws by Dr. Daniel in the Spring of 2004, there seemed to be much confusion and indecision as to how to deal with this physician. The Public Hospitals Act should identify processes for Hospitals to proactively temporarily suspend a physician's privileges for assessment and treatment of significant issues of disruptive behaviour. Currently the Act (Chapter 40, Section 34) limits immediate suspension of privileges for serious problems related only to diagnosis, care or treatment of patients and fails to address issues of disruptive behaviour which could impact hospital staff or patient care.

Coroner's Explanation: The jury is responding to the evidence of several witnesses from the hospital and the two experts in health care administration and law. Their rationale is clear.

THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL and TO THE PUBLIC HOSPITALS OF ONTARIO:

11. The Hotel-Dieu Grace Hospital and all public hospitals should conduct a review of their by-laws to ensure, to the extent that the matters below are not already addressed, that their Medical Staff Governance By-Laws and other staff policies are updated. The following principles and considerations, which have been raised by the evidence at this inquest, should be among the matters included in such a review:

12. Patient and staff safety, and quality of care must be the most important factors and not be superceded by a physician's right to practice. Hospitals should be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.

13. Adopt the approach to progressive discipline as set out in the 2006 College of Physicians and Surgeons of Ontario (CPSO) Working Document from its Disruptive Physician Behaviour Initiative.

14. Hospitals should establish clear codes of behaviour, supported by procedures that are conducive to a culture that encourages and supports early identification and intervention, meaningful discussion (including mechanisms to support complainants who are reluctant to participate in formal processes), appropriate actions and follow-through, including remedial and disciplinary action.

15. Professional staff by-laws should include expectations regarding professional behaviour and appropriate actions, including revocation or suspension of privileges, in order to address disruptive physician behaviour.

16. Professional staff by-laws should identify a probationary status for physician appointments. Probationary periods, including duration, reasons, mechanisms for monitoring and evaluation, expected outcomes and resolution should be documented. The Medical Advisory Committee (MAC) and Hospital board should approve both the probationary period and removal of probationary status.

17. The initial appointment process for physicians (including the requisite application form) should identify previous problematic behaviour or social health problems, e.g. conclusions and findings related to prior professional care or behaviour, reference concerns, criminal convictions and current legal actions or proceedings, previous voluntary or involuntary resignation during investigations, reasons for resignation from previous positions/employment/
appointments, and relevant health history including drug abuse or attempted suicide.

18. The re-appointment process (including the requisite application form) should identify any concerns (as mentioned above) that have arisen since the last appointment or re-appointment date.

19. Professional staff by-laws should ensure annual evaluation of physicians' quality of medical care, utilization of resources, completion of required programmes, and professional behaviours including interactions with patients and staff. Such evaluations should include feedback/assessments from multiple members of the healthcare team (i.e. 360 degrees).

20. Professional staff by-laws should clearly specify the roles of Chiefs of Departments and the Chief of Staff, including clear expectations for the management of disruptive behaviour.

21. The chain of command should clearly be identified to all staff to facilitate any concerns that arise and their resolution.

22. Professional staff by-laws should provide, and the Chief of Staff should ensure, that the M.A.C. and the Hospital Board shall be made aware of all re-appointment applications, including those that are being held pending further investigation or are for other reasons not being processed in the usual course (such as due to probationary agreements or leaves of absence).

23. That the Chief Executive Officer of the Hospital has the right to override the Chief of Staff and/or the Medical Advisory Committee in decisions regarding a physician's privileges when the behaviour of the physician is in violation of the hospital's codes of conduct and by-laws.

24. That members of staff and their workplace representatives should be permitted to bring directly to the attention of the hospital Board of Directors unresolved complaints of workplace violence and harassment.

Rationale: Relevant behaviour issues and complaints were not identified during Dr.Daniel's re-appointment process at the hospital. There were multiple complaints from the nurses regarding Dr.Daniel's disruptive behaviour starting in 2000 which included damage to equipment, fracture of a nurse's left ring finger, verbal abuse, unprofessional behaviour in front of patients and refusal to work with a specific nurse. Medical staff by-laws should support a culture that does not tolerate physician disruptive behaviour and make it easy to address concerns and ensure timely resolution of the issues.

Coroner's Explanation: Once again, this section is clearly explained in the jury's rationale and appears to relate to the evidence of the above-mentioned witnesses.

TO THE ONTARIO MEDICAL ASSOCIATION, DIRECTOR OF THE PHYSICIAN HEALTH PROGRAMME (PHP), THE COLLEGE OF PHYSICIANS AND SURGEONS (CPSO), THE ONTARIO HOSPITAL ASSOCIATION and to the PUBLIC HOSPITALS in ONTARIO:

The following recommendations should apply in cases of the assessment, treatment and follow-up of physicians who present with issues of mental health, and/or disruptive behaviour:

25. The PHP should have a robust assessment programme and clear guidelines for monitoring, reporting and follow-up.

26. The PHP should develop a 360-degree assessment tool to be used to determine the physician's suitability to return to work or on-call activity in cases involving mental health or disruptive behaviour issues. The tool should ensure the ability to gather relevant information from hospitals, complainants and co-workers, and other relevant parties.

27. That in any arrangements with a physician with behavioural issues that the staged approach to evaluation/assessment, management/treatment and follow-up/outcomes as identified in the taskforce report of the College of Physicians and Surgeons on Disruptive Physicians Behaviour Initiative be adopted.

28. The PHP should develop standard templates for treating clinicians, and require them to report treatment and outcomes back to the PHP.

29. The PHP should ensure that workplace monitors receive clear and complete information, at the time that they agree to serve as monitors, as to the expectations upon them, including the kinds of information that they should be seeking and reporting upon. Monitors should receive copies of the member's contract with the PHP in order to augment this information.

30. Where the member's workplace is a hospital, the chief of the medical staff at the hospital and the chief of the physician's department should be included in the member's PHP contract.

31. Where a physician's return to work is conditional upon a certification from the PHP that the physician is fit to return, there should be a full case conference involving those named in the PHP contract, prior to the issuance of such a certification to the workplace. In order to ensure the effectiveness of such case conferences, strategies need to be put into place to overcome barriers to the sharing of necessary information due to privacy concerns when abuse and harassment are issues and the safety and well being of others are engaged. Regard may be had to precedents in this area within the context of domestic abuse intervention programmes and principles for mandatory referrals to employee assistance programmes.

32. An independent assessment conducted by a professional who is completely independent of the Hospital and the physician must be completed before re-integration to work.

33. Where the member is being monitored through the PHP for a mental health issue, such monitoring should include an assessment for the potential for lethal violence. Such an assessment should always be required for patients dealing with depression or a suicide attempt or the aftermath of a separation from an intimate partner. An essential element of such monitoring is regular contact with the former intimate partner and/or workplace to ensure that there has been no abuse or that, if there has been, it has truly ended. There should not be exclusive reliance upon the patient's self-report.

34. That where the behaviour of the physician has negatively impacted on staff of the hospital, the Chief Nursing Executive be consulted regarding any concerns about the reintegration of the physician into the hospital. In addition, the nursing staff should be advised in advance of the physician's return to work date.

Rationale: Marc Daniel returned to work following the assessments of the PHP and his treating clinicians. Their letters of recommendation to return to work were based only on their interviews with Marc Daniel. There was no documentation of consultation by PHP with any of the OR nurses, the Hospital administration or Lori Dupont. When abuse and / or harassment are issues and third parties have their safety and well-being threatened, there needs to be clear releases of information that let the perpetrator know that effective treatment involves accountability and comprehensive and co-ordinated treatment services. The PHP should seek information directly from individuals who are impacted by physicians in their program and not rely solely on information from the patient, in this case, a physician.

Coroner's Explanation: The jury heard much evidence about critical information not being exchanged between the various involved parties, and this particularly affected the decision regarding Dr. Daniel's fitness to return to work.

TO THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, PUBLIC HOSPITALS IN ONTARIO AND TO THE ASSOCIATIONS LISTED (SEE SCHEDULE"A"):

35. It is recommended that all workplaces design and implement a policy to address domestic violence (also known as intimate partner violence) and abuse or harassment as it relates to the workplace. Policies must be linked to training and actual practice. The principles and considerations that should inform the review of policies in this regard include the following matters that have been raised by the evidence in this inquest:

36. Education of employees/workers/staff about the issues of domestic violence and abuse or harassment in order to help them identify an abusive relationship in which they may be involved, and about how to reach out to co-workers for assistance. The policy at each workplace should reflect an analysis of the power differentials that exist between different groups of employees/workers/staff.

37. Mediation should not be utilized for incidents of violence or abuse because of the power imbalance between the parties in these circumstances. It is even more obvious that mediation should not be utilized for repeated offences. Employers must initiate a thorough investigation when claims of misconduct in the workplace are present.

38. Training of employers and managers and, specifically within the hospital context, physician leaders, should be provided to identify signs of abuse and to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic violence.

39. All employees/physicians who are not directly involved may report a concern, but must report witnessed abusive or violent behaviour. Reports must be acted upon regardless of whether they are verbal or written. Steps taken toward incident resolution need to be communicated to appropriate workplace parties (i.e., complainant, workplace representative, JHSC, Human Resources, Occupational Health and Safety manager) in a timely manner.

40. Make available a resource list of appropriate and local referral agencies.

41. Formulate an organized response to direct threats of domestic violence, abuse, harassment, or other legitimate complaints that occur in the workplace.

42. Develop and implement a safety plan for the victim to ensure that a number of safety/security measures are in place for protection. Staff scheduling and work re-assignments and transfers should be accommodated in situations involving a component of domestic and/or workplace violence.

43. For repeat offences, an independent review by a professional experienced in the particular area of concern (eg. persons knowledgeable in the area of domestic violence or harassment), and external to the organization, is required. Workplace managers/persons in authority in such environments should enforce sanctions and consequences, especially in the case of repeated acts of such misconduct. Furthermore, these sanctions and consequences must be monitored and follow-up conducted to ensure that they are carried out effectively.

Rationale: It seemed like several people approached their supervisors or talked amongst themselves at the hospital regarding Lori's situation, as well as other incidents of Marc Daniel's abuse and harassment. However, it seems that several people were uncertain how to go about filing a complaint or addressing the situation effectively within the realms of the workplace code of conduct. A workplace needs to outline and identify the steps that need to be taken when dealing with domestic violence situations. Even with a good policy in place, without proper training it can't be implemented. It is important that the general public and professionals understand the dynamics of domestic abuse so that the signs can be recognized and concerns can be taken seriously.

Coroner's Explanation: The jury here appears to have taken into account testimony from hospital witnesses, along with the evidence of the expert witness on domestic violence who advocated development of a coordinated plan in the workplace to deal with potential domestic violence.

TO THE MINISTRY OF HEALTH AND LONG TERM CARE, THE PUBLIC HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, and the PUBLIC HOSPITALS OF ONTARIO:

44. It is recommended that Hospitals have available the services of a "diversity officer", reporting to the Hospital Administrator, who is available to consult with and provide supportive assistance to complainants and potential complainants in relation to violence, abuse and harassment on the part of co-workers, including physicians. The Ministry of Health and Long Term Care should consider and implement funding options for such positions, such as through the mechanisms of the Local Health Integrated Networks (LHINs).

Rationale: According to evidence of various members of hospital nursing and administrative staff, it was beneficial to have an unbiased resource person available to present concerns in the workplace.

Coroner's Explanation: The jury heard evidence that the hospital had originally had such a position but that the position had been eliminated. The incumbent had been viewed as a positive force in dealing with issues of discrimination and harassment and was seen to be an impartial arms-length advocate for human rights.

TO THE ONTARIO WOMEN'S DIRECTORATE, THE HOTEL-DIEU GRACE HOSPITAL, And THE PUBLIC HOSPITALS OF ONTARIO, And to THE ASSOCIATIONS LISTED (see schedule A), and to THE ONTARIO MINISTRY OF LABOUR

45. There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality and victims' responses to abuse. The programmes have to move beyond awareness to action about helpful and safe interventions for victims and perpetrators. Model programmes such as Neighbours, Friends and Families (www.neighboursfriendsandfamilies.on.ca) may be expanded in Ontario and be more directly inclusive of the role of the workplace. Skill building interventions that engage both professionals and non-professionals in practicing what they might say and do in such circumstances should be utilized in training initiatives (e.g. interactive theatre such as "Missed Opportunities").

46. It is recommended that the Health and Safety Associations (see schedule A) through consultation with the Ontario Women's Directorate develop educational material to provide support to all workplaces to train all employees/workers/staff members about the dynamics of domestic violence, abuse and harassment as well as what to do if faced with a situation where the violence enters the workplace. Employees/workers/staff should understand that they have a responsibility to report abuse and any other information that may be useful in preventing future violence. Workplaces should be encouraged to outline in a code of conduct how incidents should be reported and to whom they should be reported. This information should include the option of contacting the police directly, and

should specifically direct that such reporting of abuse ought not to be left as exclusively the responsibility of the victim.

Rationale: Dr. Daniel's depression did not appear to be viewed as a lethal risk factor for Lori Dupont. Through the evidence presented, the jury has learned that male depression can be a high risk factor for domestic homicide. There seemed to be a focus on treating and managing Marc Daniel's mood and depression without dealing with his attitudes about women, relationships and abusive behaviour.

Coroner's Explanation: This is linked to the evidence of the expert on domestic violence that a better understanding of risk factors for lethal domestic violence, and domestic violence in general, is needed.

TO FACULTIES OF MEDICINE AT ONTARIO UNIVERSITIES, TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (CPSO), THE COLLEGE OF NURSES, THE COLLEGE OF PSYCHOLOGISTS and to the ONTARIO PSYCHIATRIC ASSOCIATION:

47. It is recommended that all health care disciplines throughout their pre-service and ongoing professional development receive education in the dynamics of domestic violence and risk assessment and intervention strategies. This training should include an understanding of lethality factors and the use of standardized risk assessment tools to use when members are treating clients who may be victims or perpetrators of domestic violence including those who present with symptoms of depression, especially following an intimate relationship break-up and/or suicide attempt.

48. The Medical schools, The CPSO, The Ontario Psychiatric Association, The College of Psychologists, and the College of Nurses should give Continuing Professional Development credits for training in the areas of violence in the workplace, harassment, bullying and domestic violence.

Rationale: Through the evidence presented, it was stated that physicians are among those who are most probable to encounter victims of domestic violence. It is essential that they learn to identify and clearly prescribe treatment alternatives and options to victims and perpetrators.

Coroner's Explanation: This is self-explanatory.

TO THE ONTARIO MINISTRY OF LABOUR:

49. It is recommended that there be a review of the *Occupational Health and Safety Act* to examine the feasibility of including domestic violence (from someone at the workplace), abuse and harassment as factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well being of an employee is at issue. Specifically, the review should consider whether safety from emotional or psychological harm, rather than merely physical harm, ought to be part of the mandate of the Ministry. In this regard, the review should be directed to include an examination of the legislation and policies in place in other comparable jurisdictions, in Canada and elsewhere.

Rationale: Evidence indicated that psychological and emotional abuse can be more easily overlooked, but has long term consequences and in some cases may affect worker productivity and efficiency. It may be helpful to create another avenue for intervention through the Occupational Health and Safety Act whereby the Ministry of Labour could intervene in similar circumstances.

Coroner's Explanation: The jury appears to have accepted the recommendation of the expert witness in domestic violence that the Ministry of Labour should assume a role extending beyond actual physical violence in the workplace, and include workplace verbal or behavioural harassment in its mandate.

TO THE ONTARIO HOSPITAL ASSOCIATION, ALL HOSPITALS AND C.P.S.O.

50. In all situations involving an allegation of drug misuse, abuse or theft of drugs, and related paraphernalia from hospitals, the hospital should be required to conduct a meaningful investigation and complete and file a report to appropriate internal and/or external authorities within 30 days of such allegations or misuse of medications, surgical and/or anesthetic agents, narcotics or other controlled substances.

51. A review of the manner in which controlled substances and their wastes are handled.

52. Information regarding significant physician behavior problems should be identified by the Hospital and reported immediately to the CPSO.

53. Recognizing that processes and structures are in place, all Hospitals must ensure that employees and physicians are treated fairly and work in a safe environment.

Rationale: The evidence presented through a friend regarding Lori's discovery of drugs and syringes in Marc's car, the responding EMS workers' discovery of drugs and syringes at Marc's final suicide attempt, Lori's mother's evidence regarding drugs and syringes found at Marc's first suicide attempt, and head of security's discovery of 30 syringes in Dr. Daniel's locker after his death, are all events that offer probable cause to at the very least review the handling of medications in hospitals.

Coroner's Explanation: This is related to the testimony of the above-mentioned witnesses and the recommendation of the senior hospital physician that misuse of potentially stolen drugs from the hospital must be fully investigated.

TO THE ATTORNEY GENERAL / CROWN ATTORNEY'S OFFICE

54. The M.A.G. should ensure that in each jurisdiction in Ontario, a protocol exists between Court Administration offices and the Crown Attorney's office which will ensure that details of each peace bond application (s. 810 application) made to the court, with a component of domestic violence, is brought to the attention of the Crown Attorney's office within one working day.

55. Every Crown Attorney's office should have in place, in consultation with the local Police Service and the Victim/Witness assistance program coordinator an effective means of notifying the victim of the time and place of all hearings or procedures related to a peace bond application or charge, the victim's right to be present and shall have in place a process to notify victims who do not attend such scheduled events as to the results of the event.

56. The M.A.G. should develop an evaluation tool to periodically evaluate the effectiveness of training and to identify training needs with respect to domestic violence. The tool should also identify the extent to which training is implemented by Crown Counsel in daily practice.

57. An easily accessible process should be developed for victims and their advocates, as well as members of the public to address concerns related to issues presented before the Crown Attorneys/Assistant Crown Attorneys in Ontario.

58. Throughout Ontario, the Attorney General should ensure that there are dedicated domestic violence courts, which focus on early intervention and vigorous prosecution. These dedicated courts should be staffed by specifically trained Domestic Violence Crown Attorneys including a Victim / Witness Assistance program co-ordinator on hand to assist and advocate for the victim.

59. In the alternative to dedicated Domestic Violence Courts, the M.A.G. should consider expanding the hours of operation of the Current Court system to deal with cases relating to issues of domestic violence on an expedited basis.

60. The domestic violence court should deal with all cases of domestic violence within the jurisdiction from the initial application / bail hearing to the conclusion of the case. In addition, all breaches of bail orders relating to charges of domestic violence and all breaches or conditions related to peace bonds should be dealt with swiftly, effectively and consistently within the dedicated domestic violence court rather than within the general stream of cases conducted in the criminal courts.

61. Intentional court delays by the accused and their counsel must be discouraged and not tolerated.

Rationale: While recognizing that the Crown Attorney's office has made significant changes to address the Peace Bond process and Domestic violence cases, evidence suggests that the large volume of domestic violence cases may contribute to a lengthy wait for court dates and hearings. Given the prevalence and danger of spousal / partner abuse and the inherent dangers, adopting a streamlined process would result in an early intervention approach and be beneficial to victims as well as the treatment of perpetrators.

Coroner's Explanation: The jury here appears to be recommending that the Ministry of the Attorney General build on its initial response to include further interventions.

TO THE HOTEL-DIEU GRACE HOSPITAL

62. Dr. Peter Jaffe should be asked to conduct a review and revision of the current Hotel-Dieu Grace Workplace Violence Prevention Program and Policy and the Domestic Violence Awareness Training.

63. Hotel-Dieu Grace Hospital should engage Dr. Peter Jaffe, as per his offer, to train physicians regarding the Workplace Violence Prevention Program and Policy.

64. Conduct a review of security policies or measures in situations where employees / staff are exposed to dangers in the workplace from other staff / patients or visitors. Possible considerations could be increased security staff, "lock-down" drills, specific training for security in domestic violence and workplace violence.

Rationale: As a well-respected educator specializing in Domestic Violence and workplace violence, Dr. Jaffe's vast experience, knowledge, and common sense approach would be of tremendous benefit to all.

Coroner's Explanation: This recommendation is derived from an offer given on the witness stand to provide training and review to the HDGH by the domestic violence expert.

GENERAL

65. The Chief Coroner's Office should provide a report one year following release of the jury's recommendations, publicly reporting on the status of implementation of the recommendations and reasons provided by the parties for failure to implement any of the recommendations.

Coroner's Explanation: This is the standard practice for the Office of the Chief Coroner pre-dating this inquest.

Closing comment

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention and I will gladly correct the error.

January 29, 2008

Andrew L. McCallum, MD
Presiding Coroner

This report is available online at:

http://www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/pubs_and_reports.html

Comments and questions regarding this report may be directed to:

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